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MENTAL HYGIENE

VOL. III JANUARY, 1919 NO. 1

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MENTAL HYGIENE

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MENTAL HYGIENE will aim to bring dependable information to everyone whose interest or whose work brings him into contact with mental problems. Writers of authority will present original communications and reviews of important books; noteworthy articles in periodicals out of convenient reach of the general public will be republished; reports of surveys, special investigations, and new methods of prevention or treatment in the broad field of mental hygiene and psychopathology will be presented and discussed in as non-technical a way as possible. It is our aim to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials, and students of social problems will find the magazine of especial interest.

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MENTAL HYGIENE

VOL. III JANUARY, 1919 No. 1

EDITORIAL

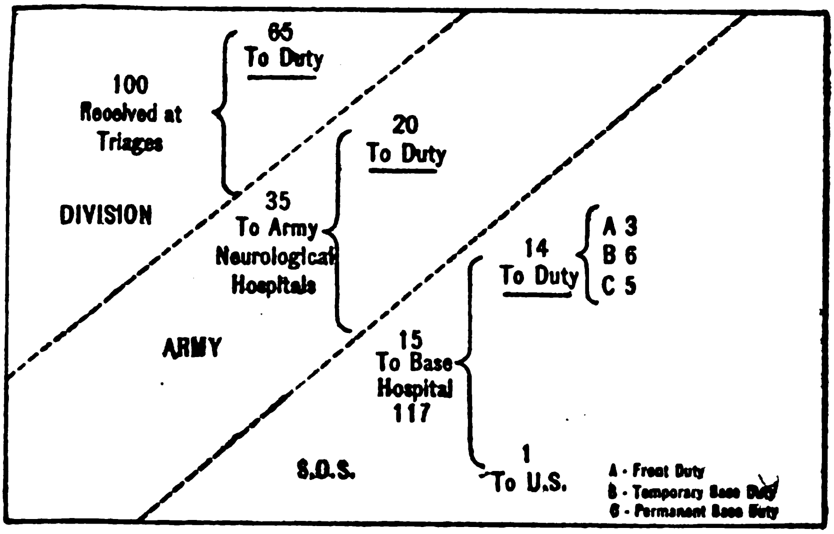
TREATMENT OF WAR NEUROSES IN ADVANCED SANITARY FORMATIONS

IT was recognized very early by the French and later by the British that the unfavorable types of war neuroses seen in military hospitals at the base and in home territory represented in a very large measure failure to deal effectively with these conditions at their inception. With this fact in mind it was determined at the outset in neuropsychiatric work in the American Expeditionary Forces to advance the treatment of these conditions as much as possible. The provision of divisional psychiatrists—medical officers with special training in the treatment of mental and nervous disorders who formed part of the sanitary personnel of each tactical division—made it possible for the American Expeditionary Forces to develop a mechanism particularly well suited for this undertaking.

In earlier operations certain administrative difficulties made it possible to deal with war neuroses in divisional hospitals only in occasional instances, but the results obtained in those divisions in which it proved feasible to station the neuropsychiatrist during combat in the *triage* or most advanced field hospital proved so brilliant that the plan was extended throughout the First Field Army. The fact that in times of stress enormous numbers of wounded passed through the *triages* of the divisions engaged in a single day necessitated a second line of defense, still within the sphere of army control. This was provided during the St. Mihiel and Argonne military operations by establishing two army neurological hospitals situated the same distance from the line as evacuation hospitals.

Now that statistics are available it is interesting to note the results of this arrangement. The number of soldiers brought to the *triages* with a history of concussion or with various functional nervous disorders ranged from three to twelve per cent of the total casualties. In the military operations mentioned the number was about 7,500. Under favorable conditions as many as eighty per cent of such cases admitted to the *triages* were returned to their organizations after an average period of treatment of less than three days. In many divisions various exigencies made the immediate evacuation of cases, favorable or unfavorable, mandatory, but the average proportion returned to duty from divisional hospitals was approximately sixty-five per cent. Of the remainder nearly all were evacuated to army neurological hospitals, only a very small number, through some mischance or another, going to evacuation hospitals and through them reaching the base. Of the cases received in Neurological Hospitals Nos. 1 and 3, attached to the First Army, approximately twenty out of every thirty-five were returned directly to their organizations and fifteen had to be evacuated for still longer treatment at the base. Nearly all the cases thus sent to the base were received at Base Hospital No. 117, a special hospital for war neuroses. The accompanying chart shows graphically the actual results obtained in all cases of concussion and functional nervous disorders in the First Army treated between September 12 and November 11, 1918.

Lessons of great importance can be drawn from this summary of the results of early treatment of war neuroses and allied conditions. It is now, happily, too late to apply these lessons to further military operations, but it is very desirable not to lose sight of the bearing of this experience upon the outcome in war neuroses generally. It is difficult to realize that conditions so easily managed with the relatively crude facilities available in advanced hospitals have anything in common with the severe and intractable neuroses which used to be seen in large numbers in base hospitals after each period of military activity. It is highly important that every one in the American Expeditionary Forces and at home should be in possession of these facts and so they are presented in this brief outline in advance of an official report upon the whole subject. These results, so highly creditable to the American Ex-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A - Front Duty
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C - Permanent Base Duty

OUTCOME OF CONCUSSION AND NERVOUS CASES ARISING IN BATTLE, SEPTEMBER 12—NOVEMBER 11, 1918 (Percentages.)

peditionary Forces, are due first to the readiness with which the Chief Surgeon of the First Army made it possible to supply the hospitals and the special method of evacuation needed while dealing with other medical and surgical problems of great urgency and magnitude, and, secondly, to the zeal, energy and devotion to duty displayed by the neuropsychiatrists in tactical divisions and in the army hospitals. These officers, without exception, felt that to let a single case become fixed while under their control would be discreditable to the standards that had been set. All worked at times under tremendous stress. In several instances the *triages*, in which the delicate and complex problems of managing war neuroses were being expertly handled, were under shell fire. Not the least important result of their work was the development among the troops engaged of an entirely different conception as to the results of concussion and nervousness in action from that previously held. In this way they were contributing directly to the morale of the organizations that they served.

MENTAL HYGIENE AND THE PUBLIC SCHOOL*

ARNOLD GESELL, PH.D., M.D.
Professor of Child Hygiene, Yale University

MENTAL power is one of our national resources. It is a rather intangible resource. It cannot be loaded into box cars, nor gathered into reservoirs, nor reported in the statistical volumes of the Department of the Interior. And yet the war has made us realize as never before, that this intangible mental resource is as real as the mountain waters which fertilize a valley or run to waste in a gorge, or turn a turbine. Almost like water power, mental power can be conserved, diverted, increased if the nation so wills. In the great war the nation so willed. And one of the most remarkable phenomena of that tremendous enterprise was the process of a democratic government commandeering, classifying, training and molding the minds of millions of its citizens.

The whole process of mobilization on its psychological side was, for one thing, a demonstration of the fact that the principles of the mental hygiene movement are well founded. I do not wish to give the term mental hygiene too sweeping a connotation, and yet in its broadest and most positive aspect, this term stands for the protection of the mental health of individuals, and the constructive conservation of the native mental power of the nation. Does not the conception of mental hygiene then seem less shadowy and less pretentious than it formerly was? The war has given almost ocular evidence that the mentality of individuals and of groups can be shaped and energized. Propaganda has become a word as suggestive as "witchcraft." By propaganda you may poison, or you may socialize minds by the thousand. Through posters, slogans, banners, lapel buttons, uniforms, headlines, you may build up prejudices, attitudes. You may even fix vast moods upon a continent of people. Psychologists were given commissions and put in uniform and officially delegated to investigate and to improve the morale of soldiers. "Morale officers," they were called. Surely applied psychology is coming to its own when its exponents are called in to increase and control so highly a psychical condition as the morale of a fighting soldier. Psychologists were assigned to cantonments where they mentally examined recruits, literally by the thousands daily. Squads numbering as high as 800 were group-tested at one time. By the date of the armistice nearly 2,000,000 soldiers had been mentally tested and given numerical intelligence ratings. So, after all, mentality is a tangible asset and may yet figure in the statistical columns of government reports.

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* Read as part of a symposium on mental hygiene and education at the annual meeting of the Massachusetts Society for Mental Hygiene, Tremont Temple, Boston, January 16, 1919. The other papers in the symposium were: "The Need for Instruction in Mental Hygiene in Medical, Law and Theological Schools," by Dr. H. Douglas Singer; "Facts of Mental Hygiene for Teachers," by Dr. Walter F. Dearborn; "Nervous Children and Their Training," by Dr. C. Macfie Campbell, and "The Smith College Experiment in Training for Psychiatric Social Work," by Dr. W. A. Neilson, pages 11, 16, 24, 59, MENTAL HYGIENE, Vol. III, No. 1.

The fact that applied psychology played such an important part in the mobilization and prosecution of the war, and came to be recognized as an indispensable instrument in the personnel work of the army, means that it will probably play an increasingly important rôle in times of peace. Already on the strength of the military experience, it has been suggested (by Professor Thorndike) that a national mental census be taken of all children of a given age—for example, all the eleven-year-old boys and girls of our country. It would not be an impossible undertaking. There are about 2,000,000 such boys and girls in the nation. Suppose we draft 200 psychologists, divide the country into as many districts, furnish them with sufficient authority and transportation facilities, and send them out over the land with their group-test sheets. They might finish the job possibly in ten days, furnishing a cross section of the juvenile mentality of the nation.

We smile at this rather ambitious suggestion, but we may prophesy that even if the federal Bureau of Education does not undertake such a large-scale psychological survey, there is none the less going to be an active season of group testing the country over. The group tests, as at present developed, are applicable only to children in and above the fourth grade. There is no doubt that we shall soon have more than one group scale, devised to test children below the fourth grade. It is possible that some psychologist has already dreamt of a method of collective testing of large groups of babies at milk stations and at child welfare conferences! It is contended that group testing has taken mental examination out of the field of the luxuries.

Do we possess in this group testing a new method for promoting and realizing mental hygiene in our schools? It seems to me gravely doubtful. Group tests at present can furnish little beyond rough intelligence ratings, and will serve only to sift and sort pronounced intellectual deviations. The whole task of mental hygiene is largely individual and demands the development of intimate, personal methods of diagnosis.

These methods must be clinical, medical in spirit; they must appreciate the complexities and subtleties of the situation, and should if anything result in a diagnosis *by* a group rather than *of* a group. The most highly developed technique of clinical medicine, well represented here in Boston, rests upon a cooperative group diagnosis and in the exacting field of mental hygiene, we may get this technique.

The development of mental hygiene, both general and specific, in the public schools depends upon a consistent program of individual attention to individual children. This program must be more biographical, more inquisitive and more solicitous than anything we have at present in our half-formed systems of school and child hygiene. Splendid accomplishments have been made through medical inspection and school nursing; but the full implications of this work should be carried out; otherwise our hygiene remains piecemeal and patchy in character. The only thoroughgoing remedy for such patchiness is a biographical interest in infants and children, which will regard the total and the continuing child and be primarily concerned in the healthy norms of his behavior. This, and nothing less than this, spells mental hygiene.

Such a biographical interest starts with the birth certificate and continues to the diploma. The mental hygiene of the child does not begin with his entrance upon school life; it goes back to the basic determiners, physical and mental, of the nursery years. The child who matriculates in the first grade has been attending preparatory school for six years; the hygienic control of that preschool period is both a logical and practical necessity.

The weighing and measuring campaign of the Children's Bureau was a definite step in this direction. We should make this campaign an established annual event. We should build up a cumulative health and development record for each child, and into this record should be read not only pounds and inches but psychological observations and measurements which have a bearing on the mental hygiene of the child, his readiness for school life, and his major developmental needs when he enters school—his speech, his play, his movements and interests, his sleep, his social traits, and particularly any disorders and peculiarities which have already caused concern to his parents. The schedule of measurements and developmental data cannot, in the beginning, be very elaborate, but even a very modest amount of biographic bookkeeping would soon reveal to school authorities an appreciable minority of children who are in need of special educational hygiene.

If there is indeed such a thing as human engineering, nothing could be more unscientific than the unceremonious, indiscriminating, wholesale method with which we admit children into our greatest social institution, the public school.

The Massachusetts Society for Mental Hygiene with the able assistance of its president has rendered a definite service in calling attention to the importance of a more thoroughgoing health examination on school entrance.* This is the strategic period in a child's life for a physical examination, at least as thoroughgoing and searching as that to which our millions of recruits were subjected in the hurried days of war. We have at any given time only 2,000,000 children six years of age, and we have the whole summer vacation in which to conduct the examinations. Let us not forget too speedily in times of armistice and peace, what really can be done in the field of human engineering if we set our wills to the task. We should make a searching examination for physical defects and deficiencies—that seems axiomatic. We should also develop a technique for recording important traits of behavior, qualities of mind, and irregularities of physiological and mental functioning, which will point to a reconstructive pedagogy during the career of the school child. It is already possible to make an intelligence rating by mental testing; the recording of other traits, emotional, volitional and social, will depend upon more biographical methods of observation. It is for this reason that some systematic connection must be made with the pre-school career of the school beginner.

We cannot, however, place full reliance even upon a thorough psycho-physical examination at school entrance. Human nature is too complex, and, as Secretary of War Baker said in regard to the personnel work in the army, routine examinations tend to become mechanical: "Now the danger that we have in this Personnel Division is that with the size of the task and the frequency of the repetition of our contact with individuals, it is likely to make us fail to remember that each man with whom we deal is more than a card in the index, and is individually a man, that he is an individual American, and that no straight-jacket set of questions will reach his ultimate possibilities."

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* Burnham, W. H. A Health Examination at School Entrance. Boston: Massachusetts Society for Mental Hygiene, 1917. Publication 27.

Gesell, Arnold. The Special Province of Child Hygiene in the Primary School. *The Child*, London, vol. 8, p. 318–23, January 1918.

We must supplement the matriculation examination, with a period of observation which will not relax during the whole school career of the child, but which will be peculiarly intensive during the first year or first semester. This first year should be an induction year. The kindergarten and first grade then become a vestibule school, where the child may be detained under a watchful semi-probationary régime which will discover and record his strength and his weakness. In other words, a child should not really enter school until he has been there for about six months! This method of induction is not inconsistent with his also leaving the letters and phonograms; but it means that the prevailing zeal of the primary school be shifted from instruction to hygiene and that the premium be placed on a new type of teacher, possessing natural and trained powers of observation, and ability to deal discriminatingly with individual children. The well trained special class teacher of mentally deficient pupils is an example of the type of teacher who needs to be incorporated into our kindergarten and first grade, as part of a program of mental hygiene in the public school.

There are of course many practical and administrative difficulties, which we have not time to discuss; but these difficulties are not insurmountable. By way of conclusion I will outline certain possibilities which seem to me to be workable, if we really believe that mental hygiene should be introduced into the public schools. These possibilities would be most applicable to a large city, but could also be worked out under rural and village conditions.

1. A hygienic supervision of the pre-school period. This to result in a cumulative biographic record of every child from birth registration to school entrance. The data to be secured by the extension of present infant welfare agencies; by elaborated periodic measuring and weighing days; by organizing grammar grade and high school pupils to assist in the accumulation of these records; by widening the scope of public health, nursing and of medicine, so that the psychological and developmental interests of young children will be more definitely included.

2. A psycho-physical entrance examination of every school beginner. This examination should be comprehensive, thoroughgoing and in close cooperation with parent or guardian; it should

also summarize and develop the main conclusions from the preschool career of the child and disclose those children either superior or atypical who most urgently need a specialized school career.

3. A reorganization of the kindergarten and first grade, which will place the first half year of school life under systematic, purposeful observation. The teachers, program, schedule and equipment and administration of this induction period to be definitely adapted to such observation and to a system of record keeping and classification of pupils, which will determine their educational hygiene in the subsequent grades.

4. The development of a new type of school nurse, who by supervision, corrective teaching, and home visitation, will further the concrete everyday tasks of mental hygiene. This psychological school nurse would be a counterpart of the medical school nurse and work in close contact with her; but she would revolve in a different circle of problems. Instead of pupils with discharging ears and deteriorating molars, her clients would be the child with night terrors, the nail biter, the over tearful child, the over silent child, the stammering child, the extremely indifferent child, the pervert, the infantile child, the unstable choreic, and a whole host of suffering, frustrated and unhealthily constituted growing minds, that we are barely aware of in a quantitative sense, because we do not have the agencies to bring them to our attention as problems of public hygiene and prophylaxis.

5. The development of reconstruction schools, of special classes and vacation camps for certain groups of children who need specialized treatment, such as the speech defective, psychopathic and nervous groups. Even one hospital type of school in a city as large as Boston could benefit a large number of children in the course of a year. To such schools, classes and camps, children could be assigned for long or short periods, and secure a combination of medical and educational treatment which alone is adequate to reconstruct them mentally. These provisions imply neurological and psychiatric specialists, educational psychologists and teacher-nurses, cooperating as public health experts in a work of mental salvage and prophylaxis. Only by such radical and sincere methods can we ever hope to reduce the massive burden of adult insanity. Expensive in the beginning, a preventive juvenile system of mental sanitation may after all prove to be a form of socialized thrift.

6. A comprehensive system of mental conservation demands also that we discover and cultivate the superior intelligence, which is at the basis of leadership and distinction in all the arts and sciences of life. Failure to afford such intelligence the optimum environment in which to grow and to produce results is incalculable waste. Psychology as a science of measurement and interpretation applied directly to problems of school administration is destined to accomplish much in this field of mental conservation.

7. Finally we have the great mass of children who are not candidates for distinction, nor victims of mental defect or disorder. Their mental welfare will depend, as always, on the traditional influences of home and school. For them, education and mental hygiene are synonymous. That education is most hygienic which provokes and promotes their intelligence, and which disposes them to become good citizens. By reason of that fact, the educators influence the ultimate mental vigor of the nation. Here lie the greatest of all possibilities in the field of mental engineering, because the great mass of children can be shaped and swayed by the methods of mass education obedient to the laws of mass psychology. Unconsciously applying those laws we have woven about our flag and the mere name of our country noble impulses of patriotism which leap to fulfillment in times of war. We can consciously apply those same powerful laws of group mentation to the less dramatic but more permanent times of peace. We need not scorn the methods of publicity, of advertising, and of association by emotional contiguity. Let us in a new way bring posters, slogans, moving pictures, group psychology, and multiple suggestion into the technique of public school education. Guided and controlled by high-minded experts in applied psychology and education, these large impressionistic methods of mental control may lift our growing generation of citizens to a higher level of civilian morale.

FACTS OF MENTAL HYGIENE FOR TEACHERS*

WALTER F. DEARBORN, M.D.
Professor of Education, Harvard University

OF the facts and considerations of mental hygiene which may be helpful to teachers, I shall place first that of *mental economy.* Too diversified work and interests bring little peace and comfort to the mind, but rather irritation and discontent. Often distracted with the many cares and duties of the school, teachers seek how they may *save* their strength and energies. True mental economy is, however, to adapt a phrase of Edmund Burke, "a distributive virtue and consists not in saving but in selection." What then shall one choose? The answer is simple, if its application is difficult: the things which one believes most worth while, and if he is to enjoy the best of mental health and happiness, these must also be the things which he most desires to do.

In teaching, the task supremely worth doing is the training and education of the individual pupils. If teachers are primarily interested in this, which is, after all, the real business of education, one of the first problems of mental hygiene is met. Mental stress and strain begin when one's work is not the expression of his desires, but conflicts with them.

Many factors and tendencies of present-day education, particularly in our highly organized school systems, make it difficult to give undivided attention to the problems of the individual pupil. The large size of classes, the special teacher for special subjects, by whom too often the subject rather than the pupil is taught, the administrative officer who looks only for the group results, all make for less attention to the individual. A recent innovation in the public schools—the so-called standard tests—may be mentioned in this connection as further illustrating this emphasis on class rather than individual considerations. These tests contribute to the organization of school work and to the definition of some of its standards; they may be made to contribute to individual instruction, but too often they lead the principal and superintendent to think chiefly of class results and scores. Superintendents have proposed making the attainment of the standard scores in what are the more mechanical aspects of school work the measure of the efficiency of teachers, and indirectly of their salaries and promotions! The teacher cannot be satisfied with the attainment of standard scores, but must consider the effect on the individual pupil: Is the pupil being educated by these tasks or is he being made into a more or less efficient machine? Is he acquiring sound interests, right habits, and worthy motives which may serve him later on in school and life, or has he simply contributed to a competitive class score, which once attained may have no further significance for him? These are the important considerations, and the teacher who puts these things first amid the distractions and competing demands will be most fruitful in his work, because he is attending to the real business of education.

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* Read as part of a symposium on mental hygiene and education at the annual meeting of the Massachusetts Society for Mental Hygiene, Tremont Temple, Boston, January 16, 1919. The other papers in the symposium were: "The Need for Instruction in Mental Hygiene in Medical, Law and Theological Schools," by Dr. H. Douglas Singer; "Mental Hygiene and the Public School," by Dr. Arnold Gesell; "Nervous Children and Their Training," by Dr. C. Macfie Campbell, and "The Smith College Experiment in Training for Psychiatric Social Work," by Dr. W. A. Neilson, pages 4, 16, 24, 59, MENTAL HYGIENE, Vol. III, No. 1.

A second consideration of mental hygiene of importance to both teachers and pupils is what Doctor Burnham, in a masterly article on *Orderly Association as a Condition of Mental Health* has called "attention to the present situation." It is, as he has noted, everywhere the type of healthful attention. I cannot do better than to quote a few significant sentences: "So important is this for the mental health that one's ability to concentrate upon the present, ignoring the past and the future except as vitally related to the present, is in a certain sense, a gauge of one's sanity."

"In the borderline neuroses, e.g., the patient worries about the past or has grave anxieties about the future. The beginning and the cause as well as a characteristic symptom of mental breakdown is the habit of doing things, as President Hyde has suggested, three times, which should be done but once: first, doing them in anticipation and dread; second, in the actual occurrence; third, in worrying about them afterwards and regretting that they had not been done differently."

" . . . Conversely, if we should attempt to sum up in one word the things that menace the mental health, this might be done best perhaps under the term interference of association."

" . . . In fact, attention to the present situation is often the best possible device for avoiding interference of association. This has always been the refuge of men in times of crisis and the anchor of sanity and health in the stress of intolerable circumstance. The mental attitude is what Plato called singlemindedness. While attention may be distributed, it should not be distracted by the complexity of a situation; and from such singlemindedness or unity of attention will be developed habits of orderly association in distinction from interference of association, which commonly occurs as the result of bad training, extreme fatigue, and nervous disorder."

To be singleminded and undistracted through the course of actions of a lifetime, the student must have discovered some permanent interests and aptitudes. Many a student flits from one task to another with soulful interest, but develops no fixity of purpose—"buzzing minds," the very variety and complexity of whose interests is a fault. All of us, as James has indicated in a brilliant passage in his *Psychology*, are under the necessity of standing by some one of our selves (or interests) and relinquishing the rest.

" . . . Not that I would not, if I could, be both handsome and fat and well dressed, and a great athlete, and make a million a year, be a wit (a *bon-vivant*), and a lady-killer, as well as a philosopher; a philanthropist, a statesman, a warrior, and African explorer, as well as a 'tone-poet' and a saint. But the thing is simply impossible. The millionaire's work would run counter to the saint's; the *bon-vivant* and the philanthropist would trip each other up; the philosopher and the lady-killer could not well keep house in the same tenement of clay. Such different characters may conceivably at the outset of life be alike *possible* to a man. But to make any one of them actual, the rest must more or less be suppressed."

To see that the natural interests and initiative of the child are not suppressed by the change to the more artificial interests of the school, to discover his aptitudes and powers, to fit the occupation and studies of the school to them, to limit ambitions within one's powers and possibilities, these are the all abiding problems of education and mental hygiene. The conflicts of desires and ambitions of adult life are among the chief subjects of discussion in mental pathology.

The movement for mental hygiene, which has been fostered by this Society, has done a great service to the community in dispelling the spectre of heredity as being, except in the cases of known physical disease, the sole cause of insanity. It is to the implications for education of this change of view to which I would next invite your attention.

There are usually constitutional factors involved, but of equal importance in many cases of mental breakdown and disaster are the faulty habits and maladjustments of the individual to the environmental or social conditions of life with which he is confronted. The roots of many of these difficulties reach back into the early years of childhood. The influences and training of the home and family are of most importance, but the responsibility is shared by the school.

The older conceptions of mental disorders gave but little hope of remedying; the newer conceptions are a challenge to the science of education and child training. Can we recognize during early school life the weaknesses, the faulty reactions and baneful influences which lead all too frequently to mental disorder and disaster in later life?

Of the characteristic types, there is time to mention but one: that so aptly described by Meyer and Hoch as the "shut in" personality, individuals who lose contact with people and things about them, no longer take part in the pleasures, the cares and activities of others, but withdraw into a world of thought and fantasy. Just as the withdrawing and defensive reactions in plants and animals indicate that the stimuli may be too strong or that the organism is not capable, has not adapted itself or learned to cope with its environment, so the withdrawing reactions of shut-in personalities may have a similar explanation. Two classes of cases may perhaps be made out for present purposes: (1) the child with inferior organization who is not able to meet the normal give and take of ordinary conditions of family and school life; (2) the child who is not so handicapped in his make-up, but whose rearing and training have been seriously at fault.

Too often the parent stands between the child and the realities of life. The child is shielded from life and protected from the consequences of his acts. His life has become "shut in" because the doors to the world of realities have been closed by too fond and protecting parents.

In the overdirection of the activities of the child in school and the failure to give opportunity for self-expression, there are similar dangers. On the other hand, the normal associations and activities, the give and take of school life, may furnish the best means of correcting these faults of early training. In this great clinic of education, the teacher will have need of all the skill which he may acquire.

A final matter about which I wish to say a word is the problem of "work" in school and industry. It is generally recognized that it is seldom hard work of itself which is the cause of mental breakdown. The neglect of the ordinary rules of physical and mental health, the loss of sleep and unhygienic surroundings have their effect, but it is rather in the overambitions and disappointments, in the worries and mental conflicts; in the humdrum and monotony of the daily tasks—which offer little chance for individual initiative and self-expression—that one seeks the causes of strain and breakdown. "Doing what we want is not work," says a distinguished engineer, "not the work we impose on the working man. Engineering is not work to me. It is my life, my way of expressing myself. I spend twelve or fourteen hours a day at engineering. I spend half an hour a day at work—reading things or doing things which I feel that I must read or do, but which themselves are disagreeable or uninteresting."

Such opportunity of self-expression is seldom given the laborer in our factories, and, I may add, in our schools. Contrast the great accomplishments of the youth of the nation in a few short months in mastering the elements of mechanics, of mathematics, and physics and chemistry, essential to the enterprises of war, to the meagre attainments of our students in college. The ordinary student notoriously finds the opportunity for the expression of his real interests in the extramural activities of the school and college. In industry there are those who, recognizing the monotonous and soul deadening character of most of specialized industry, advocate much shorter hours for work, on the ground that the laborer must find opportunities for the self-expression which are denied him in his work, in recreation.

Should not both the school and factory apply themselves to this prime problem of mental economy and hygiene, that of conserving the energies and interests of their laborers? If it is too much to expect of the factory, is it too much to expect that the work of the school should be for its students their life, their ways of expressing themselves? Most of the problems of mental hygiene would be solved if the work of both school and industry were the means of self-expression of its individual laborers.

NERVOUS CHILDREN AND THEIR TRAINING[*]

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THE healthy adult is the man or woman who not only has a healthy set of organs, but who adapts himself or herself in a well-balanced manner to the tasks, which life puts before each one. In a large number of patients the physician is perplexed by troublesome symptoms, for which there seems to be no good excuse. The stomach is sound, but the patient vomits; the heart is sound, but palpitation makes exercise impossible; eyes, teeth, nose and throat, etc., are in good condition, but the patient is kept by headache from doing useful work; the muscles seem in good condition, but the patient is incapacitated by weakness; without the usual basis being present sleeplessness, bad dreams, unpleasant sensations, unexplained aches, fears of all types, fainting attacks, combine to perplex the physician, who comforts himself by calling the symptoms nervous. The term which comforts the physician merely irritates the patient, who feels that in some way he is to blame for having such irregular disorders, for which there is not a convenient series of prescriptions.

The physician, not content with giving a name to the condition, may try to understand the origin of the symptoms; he finds that he is either dealing with patients of special sensitiveness along certain lines, or with the inability of the patient to adapt himself to definite problems in life. Inability to digest one's food may cause gastric symptoms; but similar symptoms may develop from inability to digest a distasteful situation. One man may react with a variety of disagreeable gastric reactions to trouble, which, in another, causes heart sensations, or in a third causes headache.

Such are the problems of the nervous adult, and in the study of the individual patient the physician is led back to the study of his childhood and of the influences that modified his habits; and already in childhood he may find traces of special sensitiveness or of inability to face successfully the tests of life. Frequently the tests have been made unnecessarily difficult, aid has been withheld, the child has stumbled painfully where it might have had a helping hand, has shrunk back where it might have been encouraged to proceed; sometimes special sensitiveness has been developed and fixed, instead of being modified and reduced, and hot-house care has made it difficult for the plant later to thrive in the gusty outside air.

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[*] Read as part of a symposium on mental hygiene and education at the annual meeting of the Massachusetts Society for Mental Hygiene, Tremont Temple, Boston, January 16, 1919. The other papers in the symposium were: "The Need for Instruction in Mental Hygiene in Medical, Law and Theological Schools," by Dr. H. Douglas Singer; "Mental Hygiene and the Public School," by Dr. Arnold Gesell; "Facts of Mental Hygiene for Teachers," by Dr. Walter F. Dearborn, and "The Smith College Experiment in Training for Psychiatric Social Work," by Dr. W. A. Neilson, pages 4, 11, 24, 59, MENTAL HYGIENE, Vol. III, No. 1.

A few brief records of nervous children may give a useful basis for discussion. To begin with one may choose a case where the child had some difficulty in meeting one of the most fundamental tests of life, the feeding test. The nutrition of children is an important problem, but the feeding test includes more than the problem of nutrition; it is important, of course, that the child gets a diet of the right chemical composition, it is equally important in this early contest with the environment that it should develop good habits of adapting itself to a well-regulated régime and not find an opportunity of imposing its tyranny on the environment. We are all familiar with the adult gastric invalid, whose apparent inability to digest ordinary wholesome food is a weapon of great effect; we may see the early phase of this tyrant in the following child, nine years of age. His parents brought him to the dispensary because he suffered from "nervousness and stomach trouble"; he would vomit very easily. As a baby he was nursed by his mother for two years, as she had no idea of the care of a baby. As a young child he was not capricious as to food, but he soon became so. He disliked cereal; he would not take milk, unless bribed by the addition of some coffee; he disliked eggs. If urged to take more of some food which he disliked, he would threaten to vomit, and make good his threat. His facility in vomiting was a powerful club held over his mother. He slept very heavily in the morning; in order to get him to school in time the mother would help to dress him. Instead of cultivating independence on his part, the mother had allowed this situation to develop; no doubt the mother found this dependence not altogether unwelcome, it kept her boy a baby a little longer.

The child was pushed a little too much in his studies, partly owing to the ambition of the parents; in addition to public school, he attended Hebrew school in the afternoon, in deference to the religious demands of the grandparents.

When he was six or seven the birth of a little sister made him ask his mother questions; his embarrassed mother told him the stork story. When he was eight he learned the real facts from another boy; he put them before his mother and asked her why she had deceived him. She denied the facts, reiterated the stork story. One year later he again referred to the topic and when she denied the facts he merely laughed.

This case might be used as a text for an extended commentary; a brief one will have to suffice. The boy evidently had a constitution somewhat more sensitive than the average; his vomiting mechanism was more easily touched off, and this was utilized to dominate the situation according to his caprice. This was ill preparation for a world whose dietary laws one should be trained to respect. The restless sleep and morning drowsiness were possibly related to his school routine; but this routine was not determined by objective laws of mental development, but by the ambitions of the parents and grandparents. The mother's fondness, which led her to dress and bathe the boy, was a disservice to him; it tended to foster a dependence on the mother, to develop a claim to a certain type of devotion, which might hamper him in the later development of his affections, when the time should come for him to emancipate himself from the mother and to look outside the family for a partner in life.

The treatment of this boy's nervousness did not consist in giving him tonics or sedatives, as if the tissues were at fault; it consisted in trying to cultivate better habits of adaptation to life, and in order to do so the school program had to be revised and the mother and father had to be educated in the fundamental principles of mental hygiene. Eighteen months later the boy reported that he now ate everything; his mother, however, was still bathing her ten-year-old boy.

One other point may be referred to before leaving this case. The mother had evaded the boy's direct questions as to childbirth by telling him what was not true; she had later denied the truth when he put it before her. In other words, in relation to a problem in life, which frequently proves the greatest stumbling block to sensitive constitutions, she had not only refused to give him any help, but had given him a striking example; she had indicated to him that, in relation to that topic, honesty and frankness and clear thought are not to be encouraged, and that mystery and dishonesty are to be tolerated. If we ask why the mother dealt in this way with such an important issue, the answer is on account of her own embarrassment, not on account of rational considerations. To have given the boy a good start in relation to this problem, the mother would have had to be frank with herself; she complicated the boy's life by the fact that she could not face the topic frankly. No later lecture on sex hygiene given at home or in school, at any age determined by school authorities, could erase the impression of this behavior on the part of the mother. To train the child the parent has to train himself or herself; true education must involve the parent, much as we dislike to think that our education is not completed. The time may come when special courses will be offered to parents who are still plastic and not fossilized, and who aim to adapt themselves to their children, as the more conventional education aims to adapt the children to the dogmas and prejudices of the parents.

Another boy of ten suffered from weakness and nausea in the morning; the mother said that he could not put on his clothes in the morning from weakness. He had a slightly faulty vaso-motor system as indicated by two fainting attacks and by his morning languor. He was occasionally allowed to spend the day in bed; he was irregular at school.

He frequently complained of nausea and was capricious as to his diet; he would not take milk. A competent specialist found no evidence of any gastro-intestinal disorder. An unfortunate and unjustified diagnosis of heart disease increased the solicitude of the parents. The mother stated that he *had to be* dressed every morning; she still bathed him. He had managed to dominate the environment so well that the mother could not play the piano because it annoyed the boy.

In this case one sees how the personal sentiments of the parents hampered seriously the child's development. The father, who had had a hard struggle, was now living his life again in the boy, and admitted "we indulge him—I want him to have what I have missed." He wanted the child to have those things which he had longed for, forgetting that in handing the boy these gifts without an effort on his part, he was giving the boy a poor training for life. The mother, dressing and bathing him, was hesitating to let him develop independence, just as she herself had hesitated to emancipate herself from her family. After her marriage she had visited her parents' home every morning, and if she failed to do so her father would call to see if she were perfectly well.

The frequent discussion of the whole situation with the parents led to a certain amount of cooperation on their part; they allowed him to play more freely, and to go to school regularly; the morning nausea and languor disappeared. At the last report he was able to support his mother's piano playing without any evidence of irritation.

A boy of eight, who was brought to the dispensary on account of bed-wetting, and who showed a degree of modesty very unusual for a boy of his age, showed marked capriciousness as to diet; "once every two weeks he will eat a little chicken, but on the whole it is difficult to make him eat anything. He will eat scarcely any meat except a little raw meat, which I give him about three times a week." It is probable that here, too, the faulty habits in diet were partly to be attributed to the over solicitous and over indulgent mother.

A boy of seventeen who was still apt to climb in his mother's lap and wanted to be "mother's baby," was liable to vomit if sent to school, which he disliked; the solicitous mother, therefore, allowed the boy to stay at home.

Faulty habits in regard to sleep are as frequent as those in regard to food; here too the parent is liable to put on the constitution of the child the blame which is too often due to faulty training.

Frequently when the child is removed from the mother's bed or the mother's room there is a temporary sleep disturbance; in many cases this is a sufficient excuse for the mother to resume the previous arrangement and to keep the child beside her.

A girl of six was nervous, slept badly, had night terrors; she lived with a very solicitous grandmother who was afraid to let the little one out of her sight; the child had been infected with the same attitude and would be in a panic if she missed her grandmother for a little while. If the child was afraid at night she was taken into her grandmother's bed; she went to bed when her grandmother did. She was very capricious as to her food; the grandmother thought it a shame to force her to take a regular diet. The child's lack of appetite was due to the fact that she ate candy continually. The institution of a wise and more objective régime, one condition of which was sleeping in a cot by herself, soon brought about a great improvement in the sleep of the patient.

Another illustration of sleep disturbances is given by a girl of eleven, who was taken away from school owing to her nervous behavior. As a baby she was restless, and slept little at night. The mother stated that at three years the child would *have to be* taken up, and rocked by the mother until she would go to sleep. Instead of having learned to adapt herself to a healthy régime insisted on by a wise parent, the child had formed poor associations, had managed to assert her own individual preference and had taught the mother to fall in with her demands. The mother said the child would *have to be* taken up, but this was a confession that the mother had to take her up, that the mother was unable to resist the appeal of the moment in order to establish sound sleep habits later.

Up to the age of six years the child slept in a crib in her mother's room; up to the age of eleven the mother would have to stay with her for an hour before the child would go to sleep; if the child had bad dreams and cried, she would be taken into the mother's bed. The child had St. Vitus' dance for several months.

There are children who have so arranged the household that the parent has to go to bed at an early hour, otherwise the child refuses to sleep; one little girl refused to allow her mother to leave the house after she herself had been put to bed. The mother had to remain in the house, if not in the room.

A frequent disorder of sleep is the occurrence of night terrors. In some cases no definite source of the trouble may be found; in others the night terrors seem to have some relation to the degree of stimulation of the child during the day. Thus the child may be indulging in too exciting play in the evening, or may be over stimulated by visits to moving pictures. In other cases the night terrors have a more complex origin, which it needs time and skill to trace. They are to be regarded as indicators of some disturbing element in the balance of the child and while it is well to examine the child for such simple conditions as adenoids etc., one should not ignore the possibility that the trouble is of more subtle origin in the instinctive and emotional life of the child.

Among other indications of nervousness in children may be mentioned tantrums, involuntary movements (St. Vitus' dance, tics), headache, attacks of various descriptions, precocious or anomalous sex interests or activities, romancing, morbid fears.

Children are suggestible and easily affected by those around them; the nervous child brought up in an atmosphere of headachy relatives may develop headache at an early age, and complaints of headache may become increasingly frequent. Thus school attendance may be seriously interfered with, while the headache may never appear to disturb week-end amusement. The incoordinate movements of St. Vitus' dance (excluding cases of obviously toxic origin) form a striking picture and at once proclaim the nervous child; the exact cause of the condition in each individual case requires a careful and searching scrutiny of the instinctive and emotional life of the child. Sometimes it is the result of an impressionable child's seeing a schoolmate afflicted with a similar disorder; sometimes it is related to conflicts in the sexual sphere; sometimes the physician fails to determine the exact precipitating factor. The symptoms, however, indicate that we are dealing with a nervous child, whose resistance to stress and strain is less than that of the normal child; while the régime of the patient should not tend to develop an invalid attitude it must make allowance for his special limitations. It is not enough, however, to institute such an objective impersonal régime; it is important that the physician should endeavor to get on such terms with the child that any repressed worries or conflicts of the latter can be brought up for discussion and solution. For the nervous child two conditions are eminently salutary, first a wholesome objective régime, and second an atmosphere of frankness, in which he can get a fair chance to discuss his troubles.

It is especially in relation to the sexual instinct that a healthy atmosphere is of importance to the child. The method of assimilating this instinct is one of the best tests of the nervous balance of the child. Unfortunately the conventions of the nursery and the drawing room make us blind to the first sexual interests and activities of the child, and to the resultant conflicts. Symptoms arising on this basis have got to be explained in some more palatable way. Trouble with these feelings and activities may give rise to the most varied symptoms; and to deal in a straightforward way with these symptoms means that the parent has to face in a straightforward way facts, which the usual education and training have as a rule taught him to evade. The parent who can do this is a valuable asset to the nervous child.

To sum up: No endeavor has been made in this brief paper to cover systematically the conditions which might be included under nervousness in children. The nervous symptoms, of which a few have been mentioned, are signs that the child is of rather sensitive constitution, or is forming poor habits of adaptation, or is having difficulty with important personal problems. The personality of the child is as complex, if not as richly furnished, as that of the adult.

The treatment of nervous symptoms involves the training of the child, for the nervous symptoms may be only intelligible as part of the adaptation of the child to the environment. In developing the best adaptation of the child, we must remember that as food is building up the tissues, correct habits with regard to food are helping to organize sound personality, and the same principle applies to the other bodily functions.

The physician who is confronted with the nervous symptoms of the child, finds that his task inevitably takes him into the home, and that he has to treat not a symptom but a situation. He has to sketch a program for the child and to get the cooperation of those who supervise the program, the parent and the teacher.

It is only when this cooperation is established and the missing educational links are supplied that adequate training of the nervous child, in fact of the normal child, will be attained.

THE NEED FOR INSTRUCTION IN MENTAL HYGIENE IN MEDICAL, LAW AND THEOLOGICAL SCHOOLS*

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MENTAL hygiene, or the preservation of mental health, is a term which has in recent years become so popularized that it may be well to stop and consider whether its significance has been fully grasped. That it has not seems to be strongly evidenced by the failure to develop any definitely organized system of teaching and research by the educative bodies of this and other countries.

The relation between human beings, their ability to exist and pursue their individual aims without infringing upon the rights of others, which constitute social life, are absolutely dependent upon mentality.

Social existence means the control of individual desires and the establishment of modes of adjustment between these desires, which are inherent and unescapable, and the conditions brought about by the requirements of community life. The means for these adjustments are provided in the brain which, as has been said by Adolf Meyer "in action" is the mind.

There is, therefore, no individual and no condition of human existence to which mental health is not essential.

Conversely there is no problem in the preservation of social union or community life more important than that of mental health.

But, while these assertions will be quite generally accepted, it is not so widely recognized that this implies anything more than bodily health. We are far too liable to give heed to the, in my opinion, very misleading dictum of "*mens sana in corpore sano.*"

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* Read as part of a symposium on mental hygiene and education at the annual meeting of the Massachusetts Society for Mental Hygiene, Tremont Temple, Boston, January 16, 1919. The other papers in the symposium were: "Mental Hygiene and the Public School," by Dr. Arnold Gesell; "Facts of Mental Hygiene for Teachers," by Dr. Walter F. Dearborn; "Nervous Children and Their Training," by Dr. C. Macfie Campbell, and "The Smith College Experiment in Training for Psychiatric Social Work," by Dr. W. A. Neilson, pages 4, 11, 16, 59, MENTAL HYGIENE, Vol. III, No. 1.

This phrase may easily convey the impression that disease of the body is necessary for the determination of mental disorder and thus that mental hygiene is already being adequately taught when instruction is given in the prevention of disease.

While it is true that disease of the bodily organs and especially of the brain may result in disordered behavior, it seems to me to be of prime importance to distinguish between the disease and the mental disturbance. This is essentially a distinction between structure and function, the former being the tools available and the latter the manner in which they are used. Poor work can be performed with the very best tools and good work may be accomplished even with defective tools provided there be sufficient skill, a provision which is largely dependent upon training and experience.

The damage which is done by syphilis or alcohol to the brain, and the defect in brain development which constitutes feeblemindedness are thus structural changes. They are not behavior or mental disorders but are handicaps to the accomplishment of social adjustment and hence may result in disorder of behavior.

The student of mental hygiene is concerned not only with eugenics and the prevention of syphilis, alcoholism, etc., which problems he shares in common with every other worker in the realm of hygiene but, in addition, with the question of measures which will ensure the use of the damaged or defective brains to the best advantage of which they are capable and in a manner which will not bring the individuals into conflict with society. It is this last feature which is the special province of mental hygiene.

The importance of the distinction between structural defect and functional disturbance becomes more obvious when it is realized that the great majority of mental disorders are not associated with demonstrable disease or defect of organs. Objection may be taken to this statement on the grounds that sooner or later specific defects may be discovered. Even should this be achieved it will not impair the force of the argument in the least degree.

As an illustration, readily intelligible, of the situation let us take the case of the so-called "shell shock" or war neuroses. Examples of these disorders of behavior have appeared at every stage in the increasing degrees of strain and difficulty in the situations to be faced. The difficulty of adjustment quite obviously increases with closeness of approach to battle conditions. Men have developed neuroses at every stage in this progression, acceptance by the exemption board, mobilization, training camp, embarkation, overseas transportation, debarkation, rear training camp, reserve army, front line trench and actual fighting.

The same is true for reactions to the events of civil life. The boy may more or less successfully adjust himself to the simple conditions of child and school life wherein his responsibilities are limited, only to fail upon reaching puberty or later because of difficulties resulting from social prohibitions, the emancipation from home control, sickness, increasing business responsibilities, marriage, financial stress, the climacteric or old age.

The relation between the appearance of evidences of behavior disorder and the complexity of the situations to be met is thus clear. Neither the assumption nor the demonstration of some structural deficiency in connection with such breakdowns would alter the need for efforts to avoid them although they might afford some remote possibility for the application of specific measures of prevention. It must also be remembered that while it might seem justifiable to argue that to break down at all is evidence of imperfect construction yet man is still undergoing a process of evolution and hence perfection must always be a relative term. There can be no absolute normality and it would appear that the best constructed man will show inadequacy provided only that the conditions to be faced are of sufficient difficulty.

The particular form of reaction which is adopted when an individual is called upon to face difficulties beyond his ability to meet successfully may be of many different kinds. They are grouped under the various headings of neuroses (or psychoneuroses), insanity, delinquency and crime. Feeblemindedness as already stated is a structural defect and not a behavior or mental disorder. It necessarily, however, entails limitations in the possibilities of adjustment and hence conduct which must be more or less unsocial according to the degree of defect.

Mental hygiene must therefore be provided with the means for (1) the discovery of evidences indicative of the development of habits of adjustment which will endanger or prevent a social existence, together with their causes and treatment, (2) the application of the knowledge so gained to prevention.

It is impossible to imagine any problem of more vital importance to the welfare of society and yet there is none which society is so poorly organized to meet. In every state there is a more or less extensive, elaborate and expensive machinery to care for the final consequences of such disorders in the form of asylums, jails, penitentiaries, etc., but little provision, often none at all, for preventive work.

The subject of mental hygiene extends into every branch of human endeavor and it would be a mistake to suppose that it is not widely taught under various titles and guises. It necessarily enters largely into such subjects as sociology, medicine, psychology, political science and criminology. It is taught also in special schools for the training of workers in civics and philanthropy. But there is as yet, so far as I am aware, no university which has established a department concerned with the mental factors which enter into all these branches and which would act as a clearing house for the correlation and systematization of knowledge in this field.

Clinics and laboratories for the study of disorders of behavior have been established in a few states and in some instances have affiliations, whether official or not, with universities but there is a crying need for the further development of such facilities and affiliations.

But the purpose of this paper is not so much that of the needs in the way of research as in the application of the knowledge thus gained to the service of society and the prevention of mental disorder. It is obvious that every one is vitally interested and that every citizen should receive at least as much instruction in mental as in bodily hygiene. Let us therefore consider the machinery through which such instruction must be provided.

Human behavior, or the adjustments which men make to the conditions under which they must live, is dependent upon training and experience. This training may be haphazard and result largely from the experiences of the individual himself as to the consequences which result from trial adjustments he has made on different occasions, or it may be systematic and scientifically planned to provide the additional advantage of the experience of others.

Our system of education represents an endeavor to adopt the latter course and may be said to be more or less satisfactory with the individual of average endowment and good environment but falls down when applied to the child or youth handicapped by poor brain construction or defective environment (e.g., inadequate home control, vicious associations, etc.).

The educator is thus a most important cog in the machinery for popular instruction in mental hygiene. Upon him will depend the proper selection of a curriculum and its application to fit individuals to meet the conditions of life.

He, too, must be able to recognize, in their incipiency, evidences of failure to acquire habits of behavior necessary for successful social adjustment.

Instruction in mental disorders and the means of recognizing them is therefore essential for the educator.

With the completion of the primary education there comes an added stress which is a fertile source of mental disorder, the selection and training for occupation or vocation and the development of habits of recreation. Unfortunately society has not yet reached the point where there is equal opportunity for all. Some, the great majority at present, must immediately devote themselves to wage-earning, others can secure higher education and are thus afforded the possibility of more carefully selecting their course in life.

The full advantage of this opportunity to select is, however, not generally obtained for the reason that there is little or no effort to determine the aptitude and capability of the student for meeting the requirements of the course chosen and its subsequent practice. The consequences are not entirely expressed by the large proportion of failures to complete the training. To these, large as they are, must be added the later failures many of which could well have been foreseen and avoided. Some universities do study prospective students to determine mental endowment and bodily fitness upon which they base advice as to the course to be followed. These efforts are to be highly commended but to be successful must be amplified by behavioristic studies to determine not merely the quality of the tools with which the individual is gifted but in addition the habits of using them which he has, in one way or another, developed.

The educator, however, is chiefly concerned with the training of average persons. The unusual individual, whether he be so by reason of inherited or acquired structural defect or of conditions outside himself requires special consideration which can be given only by experts.

To whom do such persons come for advice and assistance when difficulties, which may have been present, and perhaps capable of detection by a trained observer, for some years, are finally perforce recognized? There are at least three groups of professional men whose special business it is to afford advice in regard to disorder of behavior. They are the doctor, the lawyer and the clergyman.

In view of this it is indeed astounding and lamentable to have to state that a large proportion of these social workers are only incidentally trained in mental hygiene.

The demand for adequate provision for teaching and study of disorders of mental health in the training of physicians is no new one. It was voiced by Griesinger, who may be considered the father of modern psychiatry, in 1845. The true position of psychiatry as a branch of preventive medicine has been pointed out by several authors. Dr. Henry R. Stedman of the Massachusetts Society for Mental Hygiene has advocated for a number of years the inclusion of a definite course of mental hygiene in the medical curriculum.

Apart altogether from the consideration of advising cases in which social difficulties have been definitely recognized and which should be referred to specialists, the physician in general practice is called upon daily to treat conditions which are essentially mental health problems. For example, a large proportion of the cases of chronic dyspepsia, chronic constipation and chronic ailments in general, to say nothing of the great group of neuroses, are behavior disorders comparable in their method of production to the war neuroses. The failure to recognize their true significance and consequent needs in the way of relief is responsible for much suffering and social inefficiency.

In addition, the treatment of actual disease is frequently complicated by apprehensions and mental difficulties such as the care of dependents, business worries, etc., and even definite neuroses which retard and may prevent recovery. This means that the physician cannot be content, as formerly, to prescribe merely for the disease which is present but must treat the man as a whole. The importance of this factor has been widely recognized within recent years and has led to the development of the hospital social service department which is now regarded as essential. To use this to full advantage the physician must obviously be trained in the knowledge of the causes and effects of mental difficulties. A few medical schools, notably Harvard University, are offering courses in social service to medical students which should help materially in this direction.

But while these needs have been admitted there has been no systematic effort to train physicians in mental hygiene. They do receive a minimum of twenty-four hours' instruction in the form of lectures and, in many instances, clinical teaching, in insanity. This necessarily must include some consideration of the causes of those mental disorders included under the heading of insanity but cannot possibly take up behavior disorders in general.

It is often objected that the medical curriculum is already so full that there is no possibility of adding more. The answer to this objection is that much of what is taught is rendered of relatively less value because the human factor, the reaction which the man makes to his difficulties, is given no consideration. To omit this is to disregard the most potent element in the health and happiness of the patient.

To the lawyer there come for advice and assistance many forms of social difficulty but more especially those included under the headings of delinquency and crime. Only within quite recent times has the lawyer, however, realized the need for the study of the criminal rather than the crime.

In a recent report* of the Committee of the Institute of Criminal Law and Criminology, Dr. R. H. Gault gives an interesting account of the teaching of criminology in the law schools of the universities and colleges. From this report it is clear that the needs are appreciated and that instruction under various guises is offered at least in the larger institutions. In some this is practical as well as academic. But there still has been no real systematization of the subject and the report concludes with the recommendation of a definite prospectus for the establishment of a department of criminology in universities and colleges.

Criminology is only a special branch of the subject of mental health, quite comparable to that which deals with the special type of behavior disorders coming under the observation of the alienist. They have in common an important relation to structural defects and diseases such as feeblemindedness, damage resulting from alcoholic intoxication, etc.

Furthermore the needs with regard to treatment in both groups are of exactly the same type though differing in particular form. Being functional in character the essential element in both preventive and remedial measures must be education.

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* *Journal of Criminal Law* and *Criminology*, Chicago, Northwestern University Press, vol. 9, p. 354-65, November 1918.

The conclusions of the courts as to the proper disposition, or treatment, of cases, can be satisfactorily reached only when the causes of the delinquency, whether structural or environmental, and the habits of adjustment of the individual with the possibility of their correction or modification are given as full consideration as the facts concerning the crime itself.

Such important questions as that of probation or the need for institutional treatment cannot be settled by any routine procedure, such as "this is a first offense," without running the very great risk of further anti-social conduct with perhaps more serious consequences on the one hand or on the other hand the risk of jeopardizing the chances for recovery of the individual.

These questions are now being met by the establishment of psychopathic laboratories in connection with courts, of which there are several attached to juvenile courts and at least two, in Chicago and Boston, for the assistance of municipal courts.

But the establishment of these expert centers will not relieve the lawyer from the need for training in mental hygiene if he is to cooperate intelligently with and use the laboratory, and if his work is to be not only remedial but also preventive. Many lawyers still find it difficult to detach themselves from the belief that a criminal who is neither feebleminded nor insane is therefore "responsible" and a fit subject for "punishment." Nothing but a realization of the causes and nature of behavior disorders will overcome this.

To advise adequately in regard to many matters which come rather within civil than criminal practice, such as divorce proceedings, will making, etc., the same training is of the greatest value.

The functions of the clergy are quite as intimately concerned with problems of mental health as are those of the lawyer. The services rendered are more voluntary in character and have no official executive features but the clergyman or priest is perhaps more often consulted upon difficulties of social adjustment than any other professional man. Especially is this true for the minor manifestations before more official agencies are called in and at a time when it would be most reasonable to hope for successful treatment. It is his function to visit the homes and be familiar with the conditions of life and welfare of his parishioners. He stands in the position of a leader in social ideals and community welfare and devotes his life to the prevention of vice and crime and the relief of suffering and dependency. In performing these functions he is essentially an educator and he must be familiar with the possibilities for affording assistance and relief, securing occupation and providing healthy recreation and amusement which play so large a part in the treatment of mental maladjustments. His work extends to the hospitals, asylums and jails wherein he has ample opportunity for the case study of mental disorder of all kinds.

The trained social worker realizes the importance of the assistance of the church and never fails in case work to secure information which will render the possibility of this assistance available. Indeed some of the more active private agencies for social work are operated directly under the auspices of the churches themselves.

Nothing further is necessary to be said to establish the real identity between the church as a social center and as an instructor in mental hygiene. The training which is given in the divinity schools includes quite uniformly sociology and social hygiene largely of an academic character but supplemented in many cases by practical work in connection with settlement work and social service agencies. While there is thus provided instruction in the general principles of social behavior there is still need for the inclusion of the subject of mental health and its disorders with the traits indicative of danger and calling for the advice of the expert.

In urging the importance of the teaching of mental hygiene in these professional schools it is not proposed that the students become experts in mental disorders. The effort has been made to demonstrate only that each profession requires at least a general working knowledge of all branches though with special developments of its own.

REHABILITATION AND REEDUCATION—PHYSICAL, MENTAL AND SOCIAL

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THE term reeducation has come into wide usage, in both the scientific and the lay press, with differences in meaning that are not always apparent. In some cases it appears that the term is used to indicate the whole course of treatment of a certain class of injured patients who, because of injury, have become unable, or who are likely to become unable, to follow their former occupations. In this sense it includes all kinds of procedures to overcome the defects or to compensate for them. In other cases it is used to indicate only a few special processes concerned in the functional restoration of diseased and injured individuals, while in still other cases the term means the actual education of a patient along special vocational lines. Much of the confusion can be obviated if one will consider even briefly some of the steps that are taken in the restoration of diseased or disabled persons, and if for the time being the word in its general sense is laid aside and replaced by the more comprehensive term "rehabilitation," to which do not cling such diversified meanings.

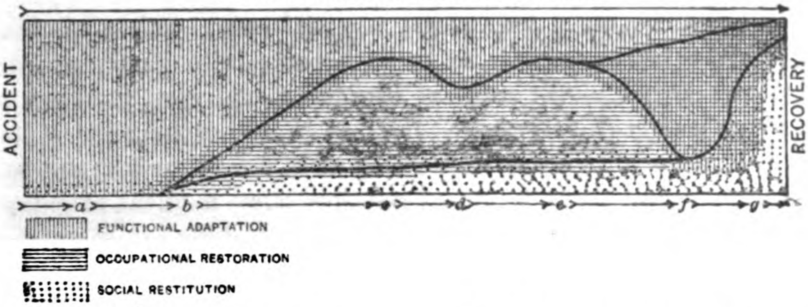
The term rehabilitation is used also for the reconstruction, or the restoration, of a damaged city or a village. It is, in fact, the restoration of a place or thing, not entirely or necessarily to its former material appearance of grandeur or color or size, but a restoration of functional value. So it is in the application to human bodies. Rehabilitation includes all of the processes that are used and the actual result of these processes, for the functional restoration of an individual who has become unable to hold his place in the social life of his community. The inability to hold a special social position may be due to disease, such as tuberculosis or typhoid fever, or to accident, whether the result of industrial life or of war, or to some unsocial act, such as a robbery, or one due to a delusion. Our present-day view of our duty towards all these kinds of individuals is, or should be, that we should do everything that can be done to make the individual a useful part of the world. This is what we mean by rehabilitation. Its processes include medical and surgical, educational, and financial and other care.

Let us now see what should and must be done to accomplish this rehabilitation in the different types which have been mentioned above, for by studying several types we shall know more about each one. The individual who is afflicted with tuberculosis is less efficient than he was before the disease attacked him. It makes little difference what the contributing causes are, he is usually unable to retain his occupation or his job. When the disease is in an active stage, if it is to be arrested, he must be cared for medically and cared for strictly. For most of the time, therefore, after the discovery of the disease, he becomes exclusively a medical case. He is put to bed, he is fed with nutritious foods, he is given rest, his mind is relieved of cares by the various social agencies that can be used to relieve his family if they are in need, or by his friends who help to look after his business. After a time his temperature becomes normal, he is able to be up for a certain part of the day. He then escapes from his merely vegetable existence and becomes more like a man with interests and with work to do. Light employment is provided, occupations that he can carry on while half sitting. His mind is being trained away from the idleness of the purely nutritive period which has been his previous hospital existence. When he is found to be able to do more than merely sit in bed, he is given other things to do. He is permitted to walk a short distance or to help the carpenter or to make a rug or a basket. As his health improves various other occupations are added; books are given him pertaining to his former occupation, or to work that will be better suited to his physical condition. He reads about and handles and works over materials used in the new occupation which he may follow instead of that which he had engaged in previous to the occurrence of the disease. Then when he is fitted to be discharged from the care of the physician or the care of the sanitarium, he is provided with a job and perhaps with a loan of money that will enable him to carry on an occupation that will be suited to him. Here we note that from the time the tuberculous condition has been recognized until the final discharge of the patient, all things are being done in order that he may be returned to the community as part of it, able to work, able to support his family and himself, and once more to be a respectable and a self-respecting citizen.

The process of recovery, from the beginning, is a continuous one, made up of parts to be sure, but with these parts closely interlaced to bring about the desired result. The parts may be separated from the whole, and we may speak of them for convenience as individual elements, but their close union prevents their being separated in practice. The conditions are illustrated in chart 1.

CHART 1

REHABILITATION OF DISEASED PATIENT



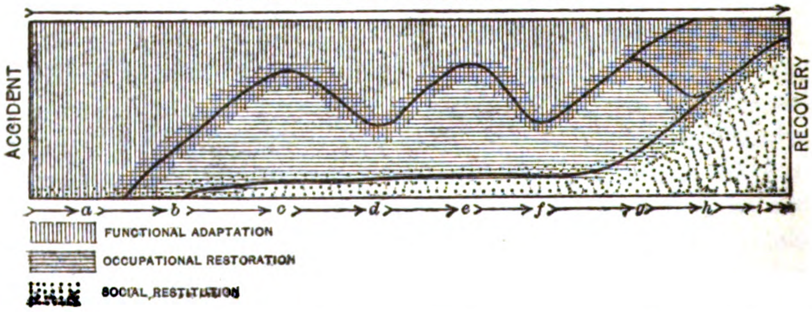
In this chart there are illustrated the three main parts in the rehabilitation of a patient with a disease. We may for convenience utilize our example of the tuberculous patient, although with slight changes the application is readily made to a case of typhoid fever, or to a case of syphilis, or to a case of heart hypertrophy with nephritis.

In the curve the time of the recognition of the disease is marked "accident." The time when the patient is fully recovered (rehabilitated) is marked "recovery." Between these two end lines the space may be considered for any special case, to be divided into days, or into weeks, or into months or years. The relative vertical distances show the general relations of the three main elements, the medical (functional adaptation), the educational (occupational restoration), and the social (social restitution). It will be noted that there is in parts considerable overlapping. No patient is entirely a surgical patient. In every case there must be considered the future. What are the possibilities of employment? What are the possibilities of so educating the patient that his former arduous work, for which he will be incapacitated, will be replaced by more suitable supervisory employment? What are the possibilities of improving his home surroundings and his social companions? Unless these questions are answered by appropriate accomplishment, the patient reverts to his former state, he becomes a medical or surgical recidivist, or a subsequent medical or surgical accident brings about the patient's death because of the lack of bodily and mental adjustment. In any case he is lost to the community as a working, partaking member.

To revert to our diagram, chart 1, we see numerous other conditions illustrated. The tuberculous patient who was taken as an example is almost entirely a case for medical attention in the period of the diagram marked *a*, but his family and business responsibilities make him partly a social case. When his temperature becomes normal, at *b*, he becomes also partly an educational case, and the amount of educational care increases as the medical care decreases. But, at *d*, either because of too strenuous work, or a slight infection as in a cold, or a temporary defect in metabolism, he again requires more medical attention. After an improvement, and a trying out in different ways at *e*, he again becomes a medical case at *f*, but only in an overlapping manner. Here he is the subject of thorough examination and consideration from the medical standpoint in conjunction with the social and the occupational, leading to his eventual discharge.

Chart 2

REHABILITATION OF INJURED PATIENT



Let us now consider another type of patient, the man who has been the victim of an accident, whether of shot or of an industrial nature. To make our comparison with the other cases which we deal with, let us suppose that the accident has been of such a character that the patient must have an arm or a leg amputated. The diagrammatic curve of rehabilitation of such a patient is shown in chart 2. In this chart the designations are the same as in chart 1, with the exception of the small letters indicating parts of the chart. At *a* the intensive surgical care is indicated, with the subsequent improvement in the patient at *b* and *c*, when a second operation is indicated at *d*, and an adjustment of an artificial limb at *f*. Up to this point the leg may have been relatively immobile. Now it is exercised with simple movements, the stump by itself and also with the appliance that has been provided. The patient learns to use the new leg just as he formerly learned to use a pencil or an umbrella. He learns to adjust himself to its weight, to its length, to its "feel," and to its peculiarities as compared with the part of the leg that was amputated. He also learns to use the new leg for more specialized things, for standing and for walking, for the operation of a sewing machine treadle or for a bicycle, or for the manipulation of a machine that comprises part of his occupational equipment. If his defect prevents his return to his former occupation he must learn a new trade, or go into some business to which the defect is not a bar, and finally, as in the preceding case, he must be adjusted to his new environment.

These two types of cases are relatively clear cut. So much interest has attached to the unfortunate "victim" of unhygienic surroundings, or of heredity, and there is so much patriotic appeal involved in dealing with a wounded soldier that the general, if not the specific, needs of reeducation or rehabilitation are recognized for those with bodily diseases or injuries. Children also touch the hearts of those who are interested in good works; and those with tuberculous hips or with the relics of poliomyelitis and even the feebleminded have their benefactors who understand the need and the value of proper care, proper occupational education, and proper social adjustments. From these classes to the psychotic, who appear to be bodily whole and bodily well but socially unadapted, is a long distance. The insane, the criminal and the beggar, are, however, amenable to reeducation. Many, if not most of them, can be rehabilitated and thus reenter into suitable social relations with others. Our greatest difficulty has been the tradition that somehow they differ from the injured and the more obviously bodily sick. While the insane are generally recognized as mentally ill, it is almost impossible to get any general support for the view that the criminal or the beggar is also, in a sense, ill.

What is a thief? Who is a prostitute? What constitutes a grafter or a beggar? These questions have been answered in general terms and at times also in specific terms separately.

return to social life. At first, at *a*, the purely medical aspect in the care of the patient is shown to be relatively important. A careful physical, including neurological, examination is given to him at this time; his teeth are examined and cared for; his heart action and the capability of his kidneys are tested and an effort made to bring about a proper adjustment if one does not exist; his eyes are fitted with glasses if they are in need of them; salvarsan is administered if his history or a serological test shows its need; and, in fact, the patient is put into as good physical shape as is possible. Besides these things his delusions are examined, recorded and explained, if an explanation appears to be advisable. As time goes on, the purely medical aspect of the care of such patient tends to decrease. At irregular intervals the medical care may become more dominant or important. There may be physical illnesses, such as influenza or one of the exanthemata, which require, for the time being, that he shall be dealt with entirely from the physical side. But the usual outstanding feature of a case of a man with a psychosis, is the lack of social adjustment, and this social side must receive at most times the major part of our attention. The failure of adjustment must be analyzed. Is it a failure due to the inability of the individual to cope with a special environment? Have too great demands been made upon his time and energy? Are the environmental factors of business or those of home the more important in the case? Are the home factors due primarily to the patient or are they due primarily to the excessive demands and requirements of his wife? Are the social factors of a religious character, and has the difficulty been exaggerated or an adjustment in the particular *milieu* been made impossible by narrowmindedness or by religious bigotry in the patient's social group? With these matters the physician may, he frequently does and should always, deal in order that he may have an understanding of the whole situation. For only by combining the mental with the physical findings are we able to do much where these two are intimately associated as in man. Apart from special theoretical considerations we must act on the belief that the physical reacts upon and affects the mental, and the mental reacts upon and affects the physical. Both must be adequately dealt with, and while the amount of each needing our attention may differ from time to time, as indicated by the variations shown in chart 3, at *a*, *g*, *h*, and *k*, each must have due consideration and none must be too exclusive. In a case of this kind the occupational element also enters; the racking stockbroker's office may need to be replaced by a farm, or possibly the solitude of farming should be replaced by the more sociable country store or be obviated by the purchase of an automobile.

When now we consider together the case of physical disease, the case of accident, and the psychotic case, the predominantly common part is the social adjustment. But what do we mean by social adjustment? How is this to be brought about? At the present time these questions cannot be answered for every individual in a specific manner. They can be answered for every one in a general way, and they can be answered for some cases in a specific way. By social adjustment we mean that an individual has acquired certain appropriate methods of reaction. He has learned, he has formed habits. These habits are of very different characters. The methods of performance of an act may differ widely in a group of individuals, but in each case the habit that has been formed must be appropriate to the social group. Take the matter of eating, as an example. It may be good form in certain social groups to use the fingers for conveying pieces of meat from one's plate to the mouth. In other social groups a "fork habit" is demanded. In traveling in a foreign country eating habits are brought to one's attention most forcibly, and the differences in the habits of various groups become apparent. Habits of dress are equally important. In some groups failure to wear a *décolleté* gown at certain functions is an offense almost as great as, if not greater than, that of being drunk. The manner of greeting one's friends and acquaintances, the expressions used in conversation and the topics discussed at dinner are also kinds of habitual reactions appropriate under certain circumstances, but not under others.

Business is also largely, if not entirely, a matter of habit. Whether or not a man sends out bills at regular intervals, reads the stock reports, or makes inquiries regarding prices before giving an order for goods, etc., are matters that mark the successful business man. He who has not formed the habit of conducting a business according to so-called business principles—which are matters of habit—does not succeed. So also with the artisan. If the carpenter uses at one time a rip saw and at another time a hand saw or a chisel for doing similar pieces of work, or if at one time he uses a hammer and at another time he uses a maul for doing similar things, he cannot expect to be successful. If he does not form the trade habits that are essential for good results he cannot succeed in his calling. Similarly with the professional man. If the physician looks at one series of incidents from a medical point of view and regards another similar series from a purely commercial viewpoint, he fails as a physician. What would one think of a physician called to attend a patient who is seriously ill, pausing to admire the artistic appearance of a weeping family group instead of attempting to do what he could for the patient? Such a man, it will be recognized, has not acquired the medical habit. He is much less physician than artist.

These considerations give not only a clue, but they also point out in no uncertain fashion the road that should be followed in rehabilitation. In every patient, disabled or injured or psychotic, what must be attempted and accomplished in order to bring about rehabilitation, is the formation of a certain set of replacing habits. These replacing habits in the case of the injured man may be similar to the old ones but carried out with another part of his body. They are habits replacing lost habits. In the case of the diseased patient they are habits which replace others that are still possible but are injurious to the patient. In the case of the psychotic they are habits that replace bad or ineffectual ones.

Some of these habits are anatomo-physiological, some are occupational, some are social. In a case of amputation two kinds of anatomo-physiological habits are demanded. One of them is that group of movement-habits of the corresponding anatomical bodily segment, or even of a non-corresponding anatomical segment, for certain reactions. The man with the right arm amputated near the shoulder must have the left arm trained in modes of reaction that will compensate for the lost right arm. If he has both arms amputated he must learn to use his legs in certain formerly untried ways. These habits are general, not specific. They are habits of grasping and of reaching and of protection. They are accommodative habits. Besides these more fundamental habits, he also requires for his maintenance others of a special kind. He must learn to write, to dress, to use a tool, to shake hands and to carry out all skilled occupational movements with the left hand and arm. The latter are his occupational habits.

But, frequently he has another kind of anatomo-physiological habit to acquire. Even though there may be only a very small stump the patient must learn to use that stump. He must form the habit of using it for the manipulation of an artificial arm. But, more than this, if he is readily educable he may learn to use a complicated artificial arm and hand by forming habits of movement-combinations with the remaining muscles of the arm and those of the shoulder. The use of many of the elaborate, recently extolled, prosthetic appliances depends upon the capability of the patient to acquire habits of new muscle-groups. The man may, for example, learn to flex an artificial thumb by moving his shoulder slightly forward in a direction perpendicular to a plane passing through the body from side to side; he may learn to flex an artificial index finger also by moving the shoulder forward, but in a direction that makes an angle of ten degrees with the perpendicular; so also with a great majority of the other movements of the hand and fingers. With a properly adjusted artificial arm new group-movement habits of the shoulder can take the place of many group-movement habits formerly carried out with the muscles of the forearm and the hand. This is a functional adaptation. It is one kind of reeducation. It is similar to, but not the same as, the use by an anatomically whole person of the toes for writing.

This functional reeducation, it must be clearly understood, cannot be separated, except logically, from the occupational reeducation or restoration. In the diseased individual the major part of the reeducational process may be occupational rather than functional. This is the case also in a psychotic patient. New occupations must be taught, and the habits appropriate to these occupations must be acquired by the patients. While these reeducative processes are being carried out, the social aspect of the individual must not be forgotten. The patient must become adjusted socially. After the loss of a leg a patient requires to be fitted with a suitable artificial one. If he insists on retaining his disability, he has failed to understand his position, his social obligations and his opportunities. His habits in the social field must then be formed and he must have a social reeducation.

With the psychotic, as has been said, the main problem is the production of a sociability to replace an unsocial or an antisocial condition. Frequently the psychotic can be changed. A habit of reacting to a complex situation can be formed. Tearing off his clothes, spitting in the faces of visitors, or doing many indecent acts can by training be replaced by other habitual modes of reaction. He learns simple things readily. His habit formation is like that of normal people. He can form the habit of reacting to complex situations if time and thought are devoted to him. His undirected or misdirected activities must be replaced by those which are social — properly directed. A habit of idleness or of vacuity can be replaced by a habit of doing something; a habit of destructiveness or ineffectiveness can be replaced by a habit of usefulness. The thief, too, can be reeducated. A social habit can be created in place of his antisocial habit. He can be taught a trade or he can learn to form the habit of producing, can be made to resist and to overcome his tendency to idleness and theft, especially if there be added a new environment. The habitual sex-offender, with suitably directed effort, may have her former activities changed by new interests, by teaching her many things she did not know, by the formation of habits of cleanliness, by giving her things to do that have definite relations to others and the future. She thus forms generalized habits of thought and action. By transplanting her to a new place in which she does not encounter old associates and those stimuli which formerly brought about her unsocial reactions, she takes a position in the social world as part of it.

All reeducation is, therefore, the same in principle. It is the formation of habits. It differs only in the amount and the direction. It is largely functional and occupational in the injured; it is largely occupational in the diseased; it is largely social in the psychotic. And, with the psychotic, as we have seen, we must, in general, group the criminal and other antisocial individuals.

We can now see the function of the so-called occupation therapy, of passive exercises including massage, of amusements of all kinds, of games, of dancing, of theatrical performances, of reading, and of many other things. In the process of rehabilitation each has a place. All should have part in the functional and in the vocational and in the social restitution, and this is the only reason for their use. There is no "reading" therapy, there is no "theatrical" therapy and there is no real "occupation" therapy. If a scrap book in any way awakens an individual who is in need of rehabilitation and who has previously been unapproachable, it can be used to inaugurate a needed train of habits. If weaving or sweeping or basket-making or working in a garden can be used to focus the attention or to employ the hands in other than destructive ways, they are useful beginnings in the reeducation process. All of these things are recognized to have a value in functional restoration; they can be made to have an even greater value in the social restitution.

Psychotherapy in its different forms is also seen to take its appropriate place. The hysteric with a functional amblyopia or with a functional paralysis recovers, he takes up his former normal habits of acting, after suggestion or persuasion or pychoanalysis. Suggestion has been defined as the acceptance of an idea. But ideas do not exist for and by themselves; they are part of a reaction chain. Every idea leads to appropriate activity, or to appropriate inhibition. The stimulus, whether this be the voice sound of the psychotherapist or a painful electric application, or a prolonged bath, tends to bring about a readjustment in the patient. The functional paralysis of an hysterical patient is a condition in which normal stimuli do not have, qualitatively and quantitatively, their usual effect. The anesthesias and the hyperesthesias are the same. In these conditions extra stimuli must be brought in to reinforce or to take the place of the more usual stimuli. The reeducation problem in suggestion is, therefore, to discover those stimuli which in a given patient will reinforce the normal or which can replace the normal stimuli. This may take only ten minutes or it may take six months. When the patient has a paralysis of the leg he may be persuaded that he can move his leg by the exhibition of a movement of the limb under electrical stimulation, or by the operator's selection of the proper combination of verbal sounds (auditory suggestion). In both cases the stimuli, whether that of seeing the leg move or that of the auditory combination, produce a cerebral or mental state in which the usual stimuli again have their effect. So also in psychoanalytic procedures. The difficulties of the patient are analyzed, and either he is informed of the reasons for his abnormalities or he is led to formulate these reasons for himself. This understanding of his difficulty results in an adjustment. If fear has produced the abnormal reaction, the abnormality may be replaced by a more normal reaction. It cannot be replaced by a reaction that would be normal for an individual who had not experienced fear. It is replaced by a reaction that is believed to be normal for those who have feared and who have escaped the object of their fears. In all this psychotherapy the effort is to replace bad or perverted habits with those of a more normal character. It is the replacement of certain abnormal habits with ones that were normal for the individual and also normal to his environment and experience previous to the exciting trauma.

Much has recently been said about the "attitude" of the patient needing reeducation. A large part of this is obviously rubbish. The remainder is mostly misdirected. "The poor wounded soldier" is thought to need encouragement, sympathy, and cheering up so much that the plan was seriously considered, and perhaps carried out, to place special "cheer up" persons with the wounded to produce in the patients a proper attitude toward their disabilities. The effect of such a procedure is very apt to be different from that expected. The best "cheer up" individual is that competent, but sympathetic, individual who takes care of the patient and starts him towards his rehabilitation. The "major doctor" need not only be feared, he can be the *nth* power cheerer-up if he has the right qualities. In other words, the attitude of those in charge of the patient is fundamentally, and primarily in time, of more importance than that of the patient. We should seek, then, to form proper habits—the most appropriate and therefore the more readily changed on account of the diversity of minds of the patients—in those who care for patients requiring rehabilitation procedures. The physician, nurse, or educator, who hands out advice and encouragement neatly wrapped up and tied with twine is not the type of man who will get results. Nor is he who, like the connoisseur, looks at the great majority as "cases" and has an interest only in the unusual and the finest gems of the collection. The surgeon and the nurse who have no interest in the eventual social restoration of the patient have not the right professional attitude. They may be like the surgeon who is said to have accomplished a successful nerve anastomosis of the central end of the accessory with the peripheral end of the facial. He produced a fine plastic, or artistic, success, with the resulting loss of the patient's capability of earning a living, for when the operation was completed he learned that his patient was a blacksmith.

The rehabilitation, then, of an individual, who is a patient because of disease, or accident, or a psychosis, demands functional, occupational and sociological procedures. These differ in relative amounts in the three classes considered, but are always found in all cases. The treatment of these three classes consists of: (a) certain strictly medical and surgical procedures, with those which make the individual adapt himself physiologically to a deficiency or to a disability; (b) training the patient in those processes which will enable him to make a living; and (c) the adjustment of the patient to a proper social environment. His reeducation comprises the formation of habits of activity, of business or labor, and of reactions to his fellows and to his physical environment. The processes are continuous and interlaced; they aim at the restoration of the individual. They are successful in so far as they are harmoniously carried out and result in the return of the individual to society, adapted to it and capable of making further needed adaptations.

THE RIGHT TO MARRY*

WHAT CAN A DEMOCRATIC CIVILIZATION DO ABOUT HEREDITY AND CHILD WELFARE?

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THE problem of heredity and the child resolves itself into two primary questions: that of marriage and prospective progeny, and that of the care of the child that is already alive.

Space forces me to limit myself to a very brief discussion of facts which it would take hours to master, and to give my consideration mainly to the question, What is to be done about it all? What makes it worth while to give these matters the attention that we investigators bestow on them and that we bespeak from the intelligent and thinking public?

Every human being is the product of the fertilization of an ovum, the product of but two of the millions of generative cells of two parents. A little consideration shows that an act of fertilization leads necessarily to but one out of thousands of possible combinations. Hence the plain obligation of the parents to keep themselves constantly healthy and in good general condition.

We all recognize the fact of heredity in the resemblance in features, function and make-up, to the one or the other parent or possibly to a grandparent or aunt or uncle, but we also know that new results will spring up in every new child owing to the inevitable individuality of every new combination.

The most vital and distinguishing features of the new bud no doubt lie in the indubitably hereditary equipment containing the factors which the parents themselves acquired from their ancestors. The further individual fate depends on individual growth and its opportunities, and opportunities of function and of training and associations, which lead to features not considered inheritable.

What we speak of as heredity in the sense of influence of the parent on the constitution of the child, is oftenest the sum of three factors: (1) genuine heredity, that which comes with the germ cells and is itself inherited—a property of the chromosomes; (2) early growth and nutrition; (3) early training and habit-formation.

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It is impossible to separate these three factors in man very clearly, owing to the long periods of gestation and infancy during which the nutrition and training problems are combined. There is, however, at times a fourth factor, more like true heredity: *i. e.*, germ damage at the time of conception, by alcohol, febrile disease and the like; or by temporary subnormalities of the parent, producing an inferiority of the stock, different from the transmission of "acquired characters." In other words, the germ plasm can be damaged permanently or for many generations by poisoning the germ cells; whereas individual injuries or experiences do not influence the stock.

For such discussion as ours, the field may be divided into two parts: First, Who is entitled to progeny and who should be considered as unfit, and what can a democratic civilization do about it? Second, What advice should be given to, and heeded by, those who have children but who realize that their progeny do not enjoy an untainted stock?

First, Who is entitled to progeny? We pride ourselves on living under the sign of a generally and freely voiced responsibility to be well ourselves and to enter upon parenthood only when there is a fair chance of giving reasonable health to the child. There may be persons who do not care and who live blindly by instinct and tradition. There are, however, many who do some thinking and feel under obligation to use their intelligence in matters of parenthood. No parent today would consider it right to give origin to a child during sickness; nor during intoxication; nor in such rapid succession as to exhaust the mother and to make her unfit to be what she ought to be to a child. And we claim that some persons should not marry at all and others only into stock distinctly better than their own.

To give a concrete picture of actual problems, I have had put together the material of four interrelated family-groups in one of our school districts. These families are represented at the public school by 35 children, fourteen of whom were found to be defective. These families were studied as wholes (about 522 persons); and then specifically, the 104 children that constitute the products of 24 matings and among whom are the 35 children in the public schools studied.

It was deemed best to group the children according to whether both parents were normal, or only one or both abnormal. The parents of the first group thus are normal or at least afflicted only by characteristics which are acquired by association, *i. e.*, likely to be the product of nurture rather than of nature. Thus we gave alcoholism and looseness of sex life the benefit of doubt, as a condition not necessarily denoting abnormal stock, but apt to be the product of unfavorable environment.

With this understanding, we found eleven matings to be those of practically normal parents; in four of these matings both parents were, however, tainted with defect—that is, having in the family cases of mental disorder or defect referable to stock and individual make-up, rather than to external causes, such as injuries. These parents show one or two defectives among their progeny, besides from three to six normal children. In the other seven matings of normal parents, of whom but one was tainted, the result was correspondingly better. In other words, it is not enough that both parents be relatively normal; but if an individual be tainted by heredity, he or she should guard against marriage with another tainted individual.

In a second group of nine matings, one parent was actually defective. Those married to normal but tainted persons produced about equal numbers of normal and defective children; whereas the six defectives married to non-tainted persons produced two defective, six uncertain and fifteen normal children. Here again, a tainted person aggravates bad parentage; a non-tainted mate reduces the risks.

The third group of matings consists of four matings where both parents were defective. The result was 21 defective, one sex offender, four uncertain and one normal. In other words, prohibition of these matings would have meant the loss of but one normal person against the prevention of over 21 defectives.

As far as we know, the great-grandparents of these families, who years ago moved into the neighborhood studied, were practically normal people, but through unfortunate cumulative matings, ignoring combinations of taint, the result described above has been obtained.

What holds for such defects as imbecility and epilepsy holds also for a number of other mental and nervous and other diseases. Only there is fortunately not the same inheritance of an actual condition but usually only of a disposition to abnormality.

We are, of course, concerned here mainly with the question of preventing further cumulative mischief by reaching the proper persons with our advice as to marriage or non-marriage.

Attempts have been made of late years to regulate this problem by legislation. The great question is, Who is to decide? A certificate exacted from a physician for two or three dollars, as was advocated in Wisconsin? Or the good sense of the community? Or a free and sensible collaboration of the responsible parties, the good sense and good will of the community, and, when needed, the help of the expert physician?

These are days of leagues of personal freedom and leagues of medical freedom and leagues protecting the privilege to get drunk and to get sick and to make others sick whenever and however you please. The worst enemy man has is his own unbridled passion and unbridled craving; and it is unbridled craving and childish fear of interference which under the glamor of freedom keep us all the more strongly in bondage. Opposed to these, there may be regulation leagues; but as intermediaries, we want at least to be sure to cultivate plain good sense and a fair chance to get and use it.

A careful student of the literature and of the facts of eugenics realizes the complexity of the problem and the reason why we should be cautious about pushing everything to the point of legislative regulation. It is in the interest of civilization to provide principles and customs rather than laws, and to give the plain sense of the individual a chance to develop and to become effective. Give the people the facts and some help to think and the right sources of advice, and there will surely be results.

Where matters are not so simple as in the case of plainly defective mentality, I urged in an address some time ago the following principle with regard to reasonable standards of the right to marry on the part of those not free from taint: We can do justice to the individual as well as to the race by making some practical conditions for such individuals to marry and have children; that is, if they can feel and give to their own sense and conscience (and I might add under the effects of three weeks' open consideration of marriage) reasonable assurance of giving a family of four children a wholesome, healthy environment and education, then even tainted persons might be allowed to marry, especially into untainted stock. If any unfavorable heredity should crop out, it would be highly probable that healthy and capable brothers and sisters would be able to assure the protection and care of the problematic abnormal individual. This excludes the marriage of imbeciles and of many psychopaths.

In this present stage of development, eugenics has no right to attempt to enforce a stronger negative policy than this. If it does so, it runs the risk of depriving the race of individuals who would be a benefit to it. I certainly should not like to miss some of the brothers and sisters of certain of my patients from this globe, nor even a good many of the actual patients themselves.

I am tempted to emphasize the fact that those who have had trouble and conquered have often been the most helpful and effective pioneers and the most thoughtful agents of constructive reform. We need persons willing to struggle and able to struggle. We must strive to avoid wanton disaster; but we must also trust our ability to save good traits and to provide, against any possible mishap, such improvements of our marriage standards that the undesirable traits may be bred out as often as they used to be bred in.

Somehow, I cannot be a fatalist. I am, therefore, very cautious about the advice to suppress nature's promptings for progeny unless I consider the mating doubly charged and the parents unfit to create a home.

What might a helpful civilization do toward preventing such disaster as is represented by the school children mentioned earlier? The first help is protection of the foolish against playing with the holiest of all sacraments—with marriage.

Under the heading of personal freedom we indulge in this country in the acceptance of common-law marriage, and marriage on marriage licenses which are, as far as I know, a mere farce, since they evidently can be obtained without any guarantee of control. The clerk can insist on forms and on a fee, but cannot guarantee controlled facts. The statements are made on oath, but I have not heard of any prosecution for perjury on the part of the state. Licenses without a provision of control have no sense.

Why not provide methods which would make control and advice at least possible? Personally, I grew up as one of a people (the Swiss) which has had a republican form of government since the year 1291—a time preceding the discovery of this continent by 200 years, and antedating the Declaration of Independence by 485 years. In that country, which certainly does not foster paternalism and disregard of personal rights, no marriage license is valid that has not been posted for three weeks by the civil authorities and published in the papers. Runaway matches and marrying parsons have no place under such conditions.

Is it asking too much in Uncle Sam's type of free country to have the sense of the people so roused that they prefer to have their personal freedom guided by three weeks of calm consideration rather than by the mere passion of a moment and false romanticism? In the families cited above, there were one girl and one boy married at fifteen years, the boy's being a decidedly unsatisfactory marriage.

Or if, in so critical a period as the consideration of marriage, we should have no confidence in our families and neighbors and in their good sense and good will, why should we not, in the ceremony itself, put the proper emphasis on the real issue of marriage? Why not replace the much-discussed question of obedience by the question, put to both parties to the life contract: Do you want this man (or this woman) and no other to be the father (or mother) of your children?

Not until some question as pointed as this, is in all cases expected and squarely asked and squarely answered as a matter of general and frank concern as soon as marriage is considered, will the rank and file of people realize the needed obligation to deal fairly with the problem of health and parental responsibility before the knot is tied. Let it be a legitimate and obligatory question and more couples will give some serious thought to what is often enough passed over because of false prudery or for lack of sense of responsibility.

Now the other point: Do not let us obscure the issue by encouraging intentionally childless marriage. The more I see of childless marriages, the more I feel their intrinsic wrong. Nine times out of ten they mean that one of the partners is exploited and condemned to forced sterility and stolen away from less selfish compacts of life. How are you going to help that? By the community's undertaking to make possible a greater measure of economic security among all classes, through sickness insurance, through the provision of medical care and of vocational training, and by practical demonstrations in the schools of the way in which the economic problems can be faced and family life made possible on a limited income.

My second problem is: What is the duty of those who have become parents but with hereditary taint?

Nobody can have absolute guaranty of healthy progeny. All parents need a good dose of preparedness to accept whatever fate may bring in their children. The progress of the world has done much to guide us if we are wise, and, fortunately, on the constructive side as well as on the preventive. Let us not forget that those who may have a tainted stock and some cause for worry may be able to make good and render valuable service to all. Those forewarned are more likely to be thoughtful about the child than those who play ostrich and make it their practical and even religious duty to be blind to the great facts of experience. And when the forewarned improve the chances of their own children, it will be for the good of all.

As far as the child itself is concerned, give it a chance to grow and to develop naturally, and consider it a duty to protect this growth and to guide rather than force it. Few realize what a hell a child's life must be when it is continually cut into by the whims and momentary or untimely good intentions and peremptory expectations of adults. Heed the many sensible suggestions which are available in such valuable documents as the publications of The National Committee for Mental Hygiene and the federal Children's Bureau.

I want to limit my special advice to tainted parents to two points: First, Do not allow yourselves to cultivate any sensitiveness about learning the facts and facing the facts about your children. Do not assume an attitude of defense or offense when anyone gives you the helpful truth. You need not talk to everybody about your grief or fears; but do not let your own false pride or conceit stand in the way of helping yourselves and the child by means of proper advice. When you see that your own resources fail, why not go over the trouble with some one who knows more about it? Why not hand over a difficult child for a time to a trained person, a school or an institution, and why not be willing to take a few lessons in child management?

When you are in doubt, it should become less and less difficult to find a medical and an educational adviser with whom you are willing to work out a careful record of the assets and of the difficulties, and of the failures and the successes of various plans tried so far. You can then expect to guide your children toward what may be best for them at the time. It is in this connection that I should like to urge you to expect ever-improving services from our schools.

Our schools must become the places where the first attempts at grading and at standardization for life should be started. Civilization is not one simple scheme and rule, but depends on a wonderful coordination of the safe knowledge and wisdom of generations on a wide range of human needs. Among other things, real civilization includes a public morality and public spirit which looks upon schools not as part of a system of political favoritism and exploitation, but as one means of bringing order into community life, of training and trying out the child in the capacities of social behavior, and of learning and working under impartial standards.

The proper collaboration of home and school is less and less vitiated by false ideals of freedom and false fears of meddling. Parents are perhaps still too ready to consider their parental feelings hurt and to withdraw the child from school when they are tempted to attribute lack of progress to the teaching or to the school. Instead of having the matter looked into by a competent and impartial inquirer, the parents and the child still are too apt to rule the situation and to blunder.

I know of parents belonging to the intellectual aristocracy who would not let their child be given a Binet-Simon test. They do not want to know the facts and prefer to be led by sentiment alone. Children who become inefficient at one school are apt to be sent to another or to work; whereas it would be in the interest of the community and the children if they were standardized and advised and taught to be respectable members of the community on their own level.

Bureaus issuing labor permits may do excellent work on this point. If a child has the misfortune of being defective, there are still some ways to be effective. To be helped to bring these effective ways to the front and to find one's level is better than being forced by foolish parents to live on bluff. In these defectives we can also train ideals and a conscience and can give them satisfactions adapted to them, instead of letting them out-marry the marriageable and out-multiply the fit.

I am skeptical about the possibility of general segregation of all those who are defective and dangerous because they are apt to reproduce their kind. We can increase our training schools and colonies but slowly, in keeping with the growth of the confidence of the people. But if we have compulsory school attendance and compulsory standardizing at school, we can certainly learn to help more persons find their sphere or level in life. This does not mean branding the child; it does mean helping him to find a sphere in which he can attain his best level in perfect respectability.

Any civilization can offer jobs to the strong worker; it takes a well-organized civilization to take care of those less favored, and to give them a life of satisfaction without jeopardy to good sense and rational freedom.

The second point of my advice to tainted parents is but an extension of this point: Train yourselves and your children to look upon physicians and hospitals and trainers as constructive rather than corrective agencies.

The most difficult cases to help are those who distrust hospital and physician and adviser, we may say, constitutionally. Familiarize yourselves with what hospitals and training schools are doing so that you may feel ready to accept their help when you need it; and inculcate in the young the right attitude toward the resources our civilization offers us.

You have little idea how many people believe training schools and mental hospitals are for what they call "the really insane" or "defective" of other families, but their own children or friends are certainly not of that class. What do people know of "classes"?

We have recently read much about a poor girl who was kept at home in a small isolated room for years, supposedly because the parents did not think of taking her to a state hospital. Need we be surprised at such ignorance as long as an interested social worker, who had been informed of our conclusion that the patient in question should be given the benefit of one of our state institutions, writes as follows:

"I am at a loss to know what is the best course to pursue in this matter. I fully appreciate that you have done all you could, but I am so anxious that nothing be spared that will possibly help this poor unfortunate girl. From a physician's point of view, would you advise further hospital treatment outside of an insane asylum? So long as she is perfectly harmless, would she stand a better chance in a medical hospital for a while longer, if we could place her?"

What does this helper of the public think of what she calls an "insane asylum"? Does she not know that our state hospitals are medical hospitals, intended to help the most hopeful and the most difficult alike and with the best medical means and judgment?

Go and teach yourselves and your children and your neighbors the fact that when anyone gets nervous and unequal to the difficulties of life, we have in our midst dispensaries and hospitals to help us on to the right track, hospitals serving as asylums for those for whom the community offers too little protection, but at the same time hospitals from which fully twenty per cent may readily come out better entitled to be called normal than if they had missed the opportunities offered by our states, and from which many apparently hopeless wrecks emerge with a gain worthy of our open gratitude instead of our frequent desire to hide the facts and to swell the false traditions of stigma, the absurd relic of fear and superstition.

If I felt that I had to conceal the fact that my own mother had two attacks of melancholia from which she recovered, I should thereby tacitly corroborate the false efforts at concealment of many others who could not conceal the fact of mental diseases in their family if they tried. Why am I able to speak freely to my own progeny about it? Because I have a conviction based on experience and on facts that many a mental disorder is much less ignominious than more than fifty per cent of the other diseases for which people have to get treatment; that many a nervous or mental disorder is the result of struggling honestly but unwisely; that many a former patient becomes a wiser element of the community when restored than the luckier, possibly thoughtless, fellow.

If there is some hereditary taint which causes you apprehension, try to prepare your offspring to live all the more wisely and to make themselves worthy of the healthiest mates. What we call insanity in a family must not be a wholesale warning against marriage. It means greater care in education and more appreciation of truly healthy strains and then either fitness to become attractive to the untainted or a choice of a life of usefulness outside of marriage.

After all, what we need most is to teach the child to wish to be well and to love the healthy. Love is very justly nature's and mankind's ablest matrimonial agent. Love plays many pranks and is said to be blind; but love, like any other capacity, can be made to grow better or worse. It certainly is taught badly or indifferently or wisely, through the way the parents love each other and through the ideals implanted in the child.

Let me state once more the main points of my appeal:

1. Help me in fighting the foolish game of trying to conceal the facts of heredity and of catering to the cruel notions of stigma. A man or a woman is primarily what he or she is, or can do; and

the knowledge of heredity will help in guiding the understanding or management of inborn traits. All this secrecy about heredity only means that other people cannot mention the facts to your face, but behind your back will talk of the skeleton in your closet. By thinking more of the safety of this closet than of actual needs, you may cheat your own people out of their best chances of getting timely care in the beginning of any trouble, and throw at the same time a slur on hospitals and on other patients, and ultimately it will fall back with a vengeance on your own family.

2. Let us not indulge in vague notions about heredity. If you want facts, let someone work up your family records as we have worked up those described in this paper. It will not do to go to a physician and ask: What do you think of heredity? But you must say: I want somebody put on the job of getting my family record worked out; and then I want your advice on various questions. No physician should prostitute himself by giving his opinion without having the family studied properly.

3. The conclusions from heredity study cannot be codified in the form of legislation. We can, however, lead people to be more responsible and to do better thinking. My two suggestions are: Turn the marriage license again into something which calls for three weeks of sound and open thinking and which is worth more than a fee and an invitation to frequent perjury which the state tolerates, thus lowering the sacredness of an oath before an official. The second suggestion would be regarding the marriage ceremony. Have it understood that in this solemn hour you have to answer the question whether you have really chosen the person whom you want to be the father or the mother of your children.

4. Let parents who know that their children may have a taint—a latent disposition or actual defect—find their compensation in the conviction that theirs is the burden of being specially mindful of the saner and sounder education of their children; and especially also a saner and sounder education in the question of what and whom and how to love.

This is not a hopeless problem. It is the biggest and finest problem of humanity.

THE SMITH COLLEGE EXPERIMENT IN TRAINING FOR PSYCHIATRIC SOCIAL WORK*

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I FEEL somewhat apologetic in appearing here as a mere layman in the company of experts and special students, because professionally I know nothing about mental hygiene and nothing about psychiatry, and am only a college administrator whose fortune it was last summer, under the stress of the war, to come into contact with the special study that brings you together here today.

Last spring the authorities of Smith College felt disturbed, like their colleagues in other institutions, at the prospect of lying idle through the summer when everyone in the country was doing an extra share in the war emergency. The result of their looking about for a profitable way to employ their equipment and their resources in summer was that they came under the advice of a sub-committee of The National Committee for Mental Hygiene; and, with the aid of the Psychopathic Department of the Boston State Hospital, especially under the influence of Dr. E. E. Southard, they undertook an entirely new experiment for them, and in some respects, as regards scale at least, a new experiment for the country as a whole. They attempted to establish a method for the training of psychiatric social workers—a phrase which I confess terrified my constituency until they learned how to spell it.

The purpose in view was to educate women so that they might help in getting up the social history of cases presented for diagnosis to psychiatrists, that they might be of use in the treatment of such cases, and that finally they might serve in the social readjustment of psychopathic cases discharged from hospitals. The interest of the moment was of course in mental and nervous disorders resulting from the war, but they were assured that this class of disorders was by no means confined to war conditions and that the profession for which they proposed to train would be a permanent one.

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* Read as part of a symposium on mental hygiene and education at the annual meeting of the Massachusetts Society for Mental Hygiene, Tremont Temple, Boston, January 16, 1919. The other papers in the symposium were: "The Need for Instruction in Mental Hygiene in Medical, Law and Theological Schools," by Dr. H. Douglas Singer; "Mental Hygiene and the Public School," by Dr. Arnold Gesell; "Facts of Mental Hygiene for Teachers," by Dr. Walter F. Dearborn, and "Nervous Children and Their Training," by Dr. C. Macfie Campbell, pages 4, 11, 16, 24, MENTAL HYGIENE, Vol. III, No. 1.

It was clearly understood from the beginning that we were not to make psychiatrists and that we were not making half-doctors. These women were to be aides to experts. The first lesson that was taught all the members of the school was professional modesty. The training given was of a variety of kinds, but closely related. The center of them all was psychiatry. The students were made familiar with the various forms of mental and nervous disorders. They were taught the more obvious symptoms, the ruling causes. They learned the vocabulary of the profession, and much of the external aspects, and a good many of the internal reasons. The idea was to make them intelligent cooperators with the psychiatric doctors. Along with this went the training in social case-work, from which they learned the method of investigating the domestic, social and industrial environment of these cases, and the influences coming from these various sources having a bearing upon the disease in question.

Along with psychiatry was taught a good deal of normal psychology; then, further outside, they had courses in sociology. Just as they learned the normal activities of the human mind in the courses in psychology as against the morbid ones in the psychiatric courses, they learned the normal organization of society, in order to know into what particular social fabric they were to aim to replace the cases that were to come under their care later.

The members of the school were mainly graduates of the women's colleges. They were selected carefully, largely by personal interview, but in some cases by correspondence. Some seventy women were collected from all over the country, twenty different states and twenty different colleges being represented. About a dozen of the seventy had not been through college, but had had what we are pleased to call the equivalent of a college education. These were mostly women who had had a good deal of social experience.

The didactic part of the course lasted for eight weeks, from the first week of July to the beginning of September, followed by six months' practical application of what had been learned, in hospitals and other social agencies in Boston, New York, Philadelphia and Baltimore. Of the fifty or more students who completed the didactic course, forty-seven are now being trained under observation, with occasional instruction and criticism, in institutions in these four cities. By March there will be about fifty-five more trained social workers in the psychiatric field than there were a year ago, through this particular experiment.

The methods of instruction were the usual ones: lectures, readings, discussions, clinical demonstrations at the neighboring state hospital for the insane, with lectures attached to these clinical observations.

The advantages of the particular experiment were, first of all, those coming from the comparative isolation of the group. The college of ordinary times of course was not there. It was during the summer vacation. These seventy women were in possession not only of the campus but also of the town. They were all doing the same kind of work. They were supposed to be active in it eight hours a day, and were in fact on the average active in it much more than that time. There were no college activities, no distractions; there was no suggestion that what they were doing in their regular work was a task and that something else was relaxation. They enjoyed their work to a degree that caused grave reflection in the minds of any person professionally engaged in education who had the advantage of beholding them. The contrast with the ordinary situation in an American so-called institution of learning was a cheering contrast as far as this school was concerned—a most depressing contrast when our ordinary institutions are considered. I should dislike to be forced to say how many weeks of regular winter work it would take to equal what was accomplished in these eight weeks in summer. The isolation and these other circumstances mentioned led to a very great intensity in their operations. The homogeneous nature of the group was also a great aid; for although their ages ran from twenty to forty-six or so, and although some of them were just out of college and others had seen a great deal of life, they were bound together for the time by this dominating interest.

A great many incidental questions were settled by the experiment. The kind of subject matter which was brought to their notice was quite frequently the kind that is not supposed to be talked about in the presence of young girls—much less, said to them. There was no nonsense among these students. There was no evidence of morbidity of any kind. They were there to learn to be of service to the community. They took their work seriously. Their intellectual curiosity was kindled and they learned a great deal and went out ready to apply it in the spirit of active social service.

This was made possible by generous cooperation. The Permanent Charity Fund of Boston provided part of the financial means. A good many of the staff of the College remained through the summer and gave their services. A very large number of distinguished psychiatrists, from the Pacific Coast to the Atlantic, came and gave one or two lectures each through the summer. There was no distinction between those who were working for a wage and those who were not, because everyone was absorbed by the interest of the experiment and the magnitude of the possible service.

There was no sentimentality about the undertaking. The students were taught and shown the particular kind of needs that they were meant to serve; they were constantly faced by unpleasant facts, and there was no need for any artificial working up of the sentimental emotions. Any decent woman would have responded as they did to the necessity for acquiring as exact knowledge as possible, and as much of it as possible, for the meeting of those needs.

Of the seventy, some three or four fell out at once, fortunately recognizing that it was no place for them. A few more, it developed, did not have the physical strength. Two or three were found not up to the mark at the examinations. The tests that were applied were as severe as the ordinary academic tests. The certificates issued to those who were to be allowed the privilege of going on with practical work were given after severe scrutiny, and all of the body of women who went out enjoyed the confidence of the lecturers who had taught them. The universal testimony of the visiting lecturers was that they had seldom had the privilege of addressing so intelligent an audience and one that seemed so worth their while.

This piece of work was done, as you perceive, under great pressure, like nearly all the war work of the colleges. The teaching part of it was condensed into eight weeks; the practical part crowded into six months. These terms would not have been chosen in ordinary times, but we did not know how dire the need might be by the coming spring for service of this kind. As it turns out, the need is not going to be so great as we feared.

We come, then, to face the normal situation of peace times—the call from psychiatrists for intelligent, trained social workers to aid and support them, and to carry out their treatment in ordinary civil cases. The question that naturally would be asked is whether this experiment is, on the part of the college, to remain an isolated one, or whether we are to go on doing this kind of thing. The answer will depend, first of all, upon the readiness with which hospitals and psychiatrists avail themselves of the services of these women when their training is finished. Some of them, those who had had social training before they came in the summer, have already been placed. Places are waiting for a number of those who are now taking the social training; and some of the others are still looking about. We expect, with a good deal of confidence, that, by the end of spring when all the students have finished, each will have found his opportunity. In this expectation we are naturally going on with further plans.

The first question that comes up is whether we should continue to try to do the thing in as great a hurry as before. It seems wise to expand it to some extent. Much of the special advantage of the situation would be lost if we attempted to bring such a group together in term time, when they would be surrounded, and I may say swamped, by two thousand undergraduates. The particular conditions, I think, can only obtain if they are there by themselves, or at least accompanied only by other workers preparing for a profession in somewhat the same spirit.

The scheme which is under preparation at the moment is to go on with this training if your experts encourage us, but to have one course of eight weeks this coming summer on the same lines as before, followed by a whole winter of practical work, more systematically supervised if possible, and with some lecture work interspersed, and completed by a second summer of eight weeks, when we shall be able to deal with these students after they know much more of the problems concerned from actual experience. This means that the ordinary college graduate who wishes to go into psychiatric work will need to add only fourteen months to her training for her bachelor's degree. That is, she will be able to begin her profession practically one year later than she normally would. Instead of beginning it in September of the year in which she graduated, she would be open for a position in September of the following year, having had, however, four months of very solid and highly concentrated specialist instruction in the classroom, and eight or nine months of practical training in the field. This would remove the training from the class of war emergency work; it would no longer be hurried—or a short cut to a profession.

The possibility of this kind of concentrated training arises partly from the external conditions I have tried to describe, but also from the fact that we are dealing with women who have learned how to study. They are trained minds, selected minds; they know what they want. They are engaged in this work, all of them, not in order to get diplomas or degrees or for "college life," but because they want to be equipped. Therefore all their energies are devoted to this one aim, and they are free from the demands of varied studies, from the feeling that it is necessary for them "to play" a large part of their time, and from the distractions of a large city. The remoteness of Northampton is a distinct advantage in this respect. From the point of view of climate, it turned out to be entirely possible. It was tried out in a pretty hot summer. The students stood it, and there is no reason to believe that they could not stand it every summer.

How long the work will be continued, how far it will be developed, depends entirely upon the reception given to the products of the school by the profession, and the supply of material. I think there will be no difficulty in getting the material. The profession is one of absorbing interest, of enormous usefulness; and it can only be a matter of a short time before its value will appear so obvious to the community at large as to insure a demand greater than the supply.

THE SOCIAL SERVICE BUREAU AT SING SING PRISON*

PAUL WANDER

Executive Secretary, Social Service Bureau, Sing Sing Prison

THE span of barely three months since the inauguration of the rehabilitation or after-care division of the Social Service Bureau of Sing Sing Prison, is too short a period to permit of drawing definite conclusions to bear on ultimate possibilities. The task of rehabilitating discharged prisoners is one that requires more or less prolonged effort with individuals and their changing circumstances, and its success cannot be determined except by reference to the end-product. What the present report can aim to do, however, is to set forth in a tentative manner the lessons of experience thus far learned as regards the nature of the task, and the policies, principles and methods shown to be adapted to its accomplishment; further, to point out some of the limitations imposed by conditions as they are met with, both inside and outside of prison, and the changes they indicate as desirable. Considering that this undertaking was conceived in a spirit of sociological experimentation, quite as much as of a specific humanitarian service, its failures should prove no less instructive than its successes, and methods as such of scarcely less scientific interest than the results themselves.

It is just to point out that the present enterprise grew naturally out of the experience of the Psychiatric Clinic at the Prison. That experience not only disclosed a proportion of recidivists at Sing Sing equal to two thirds of the total inmate population, but indicated the presence within this group of a not inconsiderable element, whose addiction to criminality seemed either curable or preventable. Our studies of the personality and life history of hundreds of inmates convinced us that, so far from being positively predetermined by inherited or biological make-up, many criminal careers are the result of the cumulative exposure of normally constituted individuals to unfavorable environmental and developmental conditions both in childhood and in later life. Among these conditions the unwise handling owing to misunderstanding of early delinquent manifestations, the later erection of social barriers and industrial obstacles in the way of the delinquent as such on the part of organized society, the consequent accentuation of his outlaw status, inviting to a predatory mode of life, and the incidental tendency to progressive deterioration in the process —these are not least instrumental in recruiting the ranks of our recidivist army.

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* The Psychiatric Clinic, under the directorship of Dr. Bernard Glueck and the auspices of The National Committee for Mental Hygiene, made its first contribution as a criminological laboratory in the form of a mental survey of the population of Sing Sing Prison, with the aim of assisting in the definition and the more intelligent administration of the human problems involved. It next undertook more intensive studies of series of selected cases, which led, in turn, to the establishment of the Social Service Bureau with its major purpose that of following up individuals, many of them previously studied as inmates, as they pass out into the community to resume life as ex-convicts. This article is the first quarterly report of the rehabilitation division of the Bureau.

It was to test out our hypothesis and to determine by actual experiment whether and to what extent the repeated and habitual offender was indeed fated to continue indefinitely within that vicious circle of crime and punishment, or whether by a deliberate and sustained effort at understanding and refitting him into a normal environment, a sufficient modification in his habits and attitudes were yet practicable to effect his permanent reclamation to law-abiding citizenship. Incidentally, in the course of such treatment, with its inevitable ups and downs, it was hoped that the trained observer directing it would gain much insight into the concrete forces making for success and failure in the individual case. The follow-up work should, on the one hand, disclose the typical problems, handicaps, needs and capacities of the discharged man for adjusting himself to the requirements of free life, and, on the other, the state of preparedness of the community for facilitating such readjustment. Functioning in this comprehensive manner as a criminological experiment station, the usefulness of a social service bureau would not be limited to the mere hand-to-mouth aid that it furnishes in the form of employment and emergency relief. By subordinating these material services to the larger purpose of reconstruction of the man and his environment, and by organizing them into a plan of action and observation suggested by the facts in each particular case, it was anticipated by the founders that a broad scientific foundation could be laid for a system of after-care that should aim at nothing less than the prevention and cure of recidivism in the community.

But the rehabilitation of the discharged prisoner is not only a means to this end of increasing domestic security, it is an end in itself. The man who leaves prison after a term of confinement with the intention of conducting himself lawfully outside is entitled to an equal opportunity with other men, which in this case means special attention and assistance in overcoming his social handicaps and adapting himself to the requirements of life in the community. His reformation must be a by-product of his rehabilitation. The notion that the reformation of the offender is ever fully accomplished within prison walls should now be discarded as erroneous. At least, so far as prisons are designed for punishment they have no such constructive potency. Only a normal social situation can call out and fix in habit those types of behavior which are normally desirable or permissible. The prison environment is at best artificially simplified and stereotyped, and therefore not adapted to test or develop those very powers of initiative, choice, and inhibition that are essential for the business of free life. The reformation of a delinquent, so far from being guaranteed by his "good behavior" in prison or by his profession of good intentions, is attested rather by the slow, painful, wearisome efforts he puts forth from the time of his liberation in the direction of recovering his place as a self-respecting member of society.

Something can, indeed, be attempted even in prison, and not a little is already being done at Sing Sing, to prepare prisoners through education and practice in self-government for the proper use of a limited freedom and to foster in them such wholesome social attitudes as will upon their release carry them more surely over the critical stage of transition. To be sure, different individuals react in a widely differing manner and degree to the stimulations of prison discipline, and a few are not perceptibly affected at all by repeated incarceration. But that most men do respond to a "square deal" and that the present liberal régime bears fruit in a greater readiness on their part to accept suggestions and guidance, have been made evident by our experience. On the whole, it is probably less true of Sing Sing today than of any similar institution in the country, that, as one inmate cynically expressed it "a man begins to reform the day he steps out of the front gate."

Unfortunately, the recent suspension of the Psychiatric Clinic on account of the war, closes one fruitful avenue of consciously reconstructive approach to those men who seek expert counsel while still in prison. But notwithstanding this handicap under which the Social Service Bureau must labor for the present, it will endeavor to reach and to influence in some measure each prisoner shortly before his discharge. It is not assumed that any profound modification of purpose can be effected by an interview or two or that an eleventh-hour decision has the same practical validity as a conviction arrived at naturally, through reflection, and gradually, through sub-conscious socialization. But it is no longer doubtful that the contact made at the prison by way of offering to the man individually the services of the Bureau may serve to reenforce tendencies and clinch resolutions already forming by making palpable to him the possibility of finding agreeable employment at adequate rates of pay and of otherwise making his peace with society.

In estimating the task undertaken by the out-clinic or after-care department of the Social Service Bureau, it is well to keep in mind that we have set out to serve not the "first termer" or the "accidental offender" (who on release passes automatically into the custody of some established parole agency), but the repeated offender, the habitual delinquent and the professional criminal. Underlying this selection of what is apparently the most unpromising material is the belief, which experience is coming to support, that perverse human behavior, in so far as the perversity is an acquired adaptation and not organically rooted in constitutional defects, is within varying limits and under favorable environmental conditions amenable to rectification. To provide, so far as possible, these favorable conditions is the primary preoccupation of the after-care service. Its second concern is to assist the individual in the process of fitting himself successfully into the new environment—a process involving, it may be, the re-conditioning of his outlook, attitude, and desires, the more or less radical reconstruction of his personal habits, activities and social relationships. Obviously, this conception of rehabilitation makes it anything but a simple or an easy task. The problem differs enormously with different individuals and situations. It grows more complex and difficult the more inadequate the personality, either due to original defects or in consequence of deterioration, and the fewer normal social ties remaining intact. Intensive individualization is the keynote of procedure in after-care as was the case at the Clinic. The conventional categories marking off "reformable" from "irreformable" offenders on the mere ground of recidivism in crime must be subjected anew to experimental test. No such moral distinction as that between the worthy and the unworthy is legitimate for our purposes, at any rate not as an *a priori* judgment based on criminal record. It may well be, and indeed nothing is nearer probability, that even the most conscientious and persistent treatment that an out-clinic can afford, short of continuous oversight, will fail to reclaim certain individuals or types of individuals to good citizenship. The decision, however, that they are hopeless must await experience in the actual handling of the case outside of prison. Even a psychiatric clinical diagnosis made within prison has for this purpose only provisional force. That is to say, while it is possible to predict in general widely divergent responses on the part of ex-prisoners to our efforts at their rehabilitation, and while with the aid of a psychiatric clinic and scientific study of individual inmates prior to their discharge a more or less dependable guess may be advanced in the given case as to its probable outcome, certainty in prognosis must always rest with actual observation under the concrete conditions of free life. This observation, recording and interpretation of the facts constitute the third and ultimate object of the after-care clinic.

If one were to pass in review the forty odd cases thus far handled, the most striking result to be noted would not be the occasional abuse of confidence on the part of men who accept favors with no intention of making good the obligation incurred; nor the rarer instances of sullen rejection of our proffered help, by men whose spirits are embittered and whose antisocial grudges grow by what they feed on, rendering them suspicious of any uplift approach, however sincere. Rather, it would be the unexpected and frequently unpredictable recovery of men whose past careers have been those of chronic transgression of the laws of property and of honesty. A number of these have resolutely entered upon lives of industry and respectability and seem to give every indication of permanent restoration. These are now no longer in need of supervision, although the facilities of the Bureau remain at their disposal.

Another group of cases illustrates the practical insufficiency of mere good resolutions. They are the men whose psychopathic tendencies and instabilities of one sort or another, while not such as under favorable economic conditions would lead them directly back to crime, yet prevent them from independently achieving enduring adaptation to their industrial environment and thus keep them constantly exposed to stresses and temptations to relapse. If these men are offered timely moral guidance and, occasionally, material support in their struggle toward adjustment, without at any time being allowed to develop a parasitic tendency to lean, it is believed that a considerable proportion—at least of the intellectually normal in this group—may be rendered safe and self-supporting, if not conspicuously useful, members of the community.

Finally, there is the group of the unregenerate, those who are uncertain in their own minds whether, after all, crime cannot be made to pay, or at any rate, are unwilling to impose upon themselves the burden of responsibility and self-restraint demanded by a life of honest self-support as distinguished from their self-indulgent, easy-going ways of the past—ways that have become second nature and more or less fixed habit. These individuals are relatively fewer and their type less pronounced at Sing Sing than elsewhere. They do not seem to flourish under the enlightened government and the healthy communal life conditions provided here. Humane and just treatment along with adequate opportunity for self-expression has proved a most potent solvent of the obduracy and soddenness of spirit, itself the product of past repressions, which is the characteristic mental twist of the recidivist as a class. But even these frankly antagonistic individuals, who persistently choose to prey upon society as marking for them the path of least resistance, are not infrequently accessible to a rational approach, if their suspicions are once allayed by a single convincing proof of sincerity. Then, if they can be shown an alternative way of life, promising security in return for industry, those of normal mental make-up may be expected to embrace it. Several instances of this character are already recorded in the experience of the Bureau.

The manner of procedure followed in this work varies of necessity with each individual case, being adapted to the needs and possibilities of the particular situation. Its general outlines, however, may be illuminated by citing a few actual cases in abstract:

M. is a young Irish-American of 29, whose fatherless boyhood and adolescence were spent partly in poverty-stricken tenement neighborhoods of New York and partly in reformatory institutions. He is generally crude in manner and primitive in his tastes and interests, suggestible, but fairly alert intellectually. As a boy, he was unmanageable and developed into a quasi-professional thief. According to his own admission he had never worked as long as three weeks in one place of employment, and his contacts with industry were not *bona fide*, at any time. His criminalistic tendencies were complicated, moreover, by an almost pathological addiction to alcohol, which at one time brought him to the verge of delirium tremens. Besides having spent a term at Elmira and having failed on parole, he had already served at least two terms in state prisons, one at Auburn and one at Sing Sing.

Soon after his reception at Sing Sing, M. was examined at the Clinic and a diagnosis of alcoholic deterioration established. The prognosis in his case was considered otherwise favorable. Shortly before his discharge, which occurred April 10, M. was again interviewed by the Director of the Clinic and subsequently by the writer with reference to planning his rehabilitation. He showed a willingness to turn over a new leaf and for the first time in his life to work voluntarily for a livelihood. Having an aged mother dependent upon him and a rudimentary knowledge of a trade that he had learned in prison, the offer of a good wage in a shipyard appealed to him as a desirable alternative to the career of a thief or that of a counterfeiter, which he claimed would be open for him even though under increased risk. But his purpose was by no means single, and when on the eve of his release he had not been formally notified of an actual position secured for him outside, he vehemently denounced the Bureau to some of his fellows and threatened to resume his "graft." On the following morning, however, he was met at the railway station by the Agent of the Bureau, accompanied to the city, and promptly provided with an introduction to one of the shipyards in the harbor. For some reason of his own he did not go there, but found work in a few days as helper at a ship-repair dock on the river, which suited him better. There he has worked intermittently ever since. On several occasions, however, he almost lost his position by failing to report for work regularly, and each time was reinstated by the employer through the efforts of the Agent on his behalf. Twice during this period of two months, M. went on a "spree" for several days or a week and for some time thereafter required material relief to maintain his household pending receipt of further wages. But for these emergency loans, there is every reason to believe he would have reverted to crime before now. As his second yielding to alcohol occurred in spite of a solemn promise to abstain, the question arises whether he be capable of abstinence at all, and, if not, what restraints should be placed upon his freedom to prevent further deterioration and failure. Apart from moments of discouragement brought on by his lapses, his resolution to "keep straight" has been greatly fortified by his favorable experience as a workman. The immediate need in his case, short of commitment to an inebriate colony, is constant and helpful oversight for an indeterminate period such as only a volunteer or "big brother" can afford to give. This would involve providing wholesome recreational outlets, social expression, intellectual and emotional stimulation to absorb his leisure, to create higher interests and to counteract the unwholesome influence of his environment and associations outside the home to which he is still exposed. In addition, such guidance would involve the cultivation not only of his normal industrial ambition—to achieve the rank and wages of a qualified mechanic in his trade—but also of the indispensable means to the attainment of this aim. Among these means are (1) building up habits of regularity and self-discipline at work, (2) holding his position as helper while perfecting his technical knowledge and skill, (3) saving of his wages and spending prudently to insure himself against unavoidable unemployment and further debts and (4) acquiring by his own effort the needed tools of his craft.

Another case, presenting a very different type of recovery, is that of F., aged thirty-three, a German by birth and education, who came to this country eighteen years ago owing to friction in the home, and who, after some unfortunate industrial experiences here, drifted through evil associations into the career of a thief. The cause of his downfall was primarily economic pressure, but this was complicated by his friendless condition and lack of disinterested guidance and protection against exploitation and discouragement. His experience as an inmate of Elmira and Napanoch Reformatories was such as to fill him with a keen bitterness against the agencies of the law, an attitude that led him straight back into crime. A truly intelligent parole service would have intervened in time to save this boy from relapsing—a task which, in view of his good mentality and of recent events, should have been entirely feasible. The same applies to his subsequent prison terms, of which he served four, and after none of which was a hand of friendship stretched out to help him back into respectability. Each time he returned to the well-known paths where he was sure of a welcome from former pals. When, therefore, he found during his last term at Sing Sing that he could look forward to earning an honest livelihood outside, and that certain people, whose motives he had learned to trust, would help him get on his feet and to escape once for all from the rut into which he had fallen, he was not slow to avail himself of the opportunity and to entrust his guidance to the Social Service Bureau even before his release. Despite the double handicap of his status as an enemy alien and an ex-prisoner without a trade, he promptly obtained employment under conditions and at wages that not only satisfy his present needs but enable him to lay secure foundations for the future. At present he is no longer in the remotest degree of danger of relapse, either by spiritual attitude or by material circumstance. In the event of stress he would know where to turn for help and counsel.

D. is an Irish-American of forty-five, somewhat deteriorated by alcoholic excesses and a generally irregular manner of life, whose long and dramatic career as a professional thief had made him a familiar figure in the underworld at its most sordid and degraded levels. He had plied his trade in many cities and states, and frequently had operated with the corrupt connivance of the police, sharing his loot freely in return for temporary immunity from arrest. Thus licensed for crime, he had come to regard with a cynical contempt the agents and defenders of the law as hypocrites, and his own occupation as at least relatively justifiable. His repeated confinement in prisons had only served to intensify his antagonism to social order as he knew it, and even his last term of five years at Sing Sing has scarcely mollified his embittered feelings. When at the end he learned that for some reason his term in prison was arbitrarily prolonged two days, he was in no mood to credit his penal experience with any redemptive virtue. He had been, throughout his term, employed in the shoe shop of the institution, an occupation in which he had had some previous experience. In speaking of this to the writer, he complained bitterly of the "instructor" who had spitefully prevented him from learning to operate a lasting machine in this prison shop, when permission to do so would not have interfered appreciably with his productivity at his assigned routine task. It was the one definite benefit his incarceration could have extended to him. As it was, he profited nothing industrially by the years spent by him in this shop, and accordingly worked listlessly and inefficiently, especially toward the end. To the assurance from us that if he were so minded, we were ready to find him a position at his trade at good wages, he responded by declaring his own readiness to abandon the ways of crime for the path of honest labor, provided it were not too straight and narrow. On reporting at our office on the Saturday morning of his release, he was immediately introduced to a leading shoe manufacturer in Brooklyn, where an interview with the foreman on the following Monday morning resulted in his being accepted on condition of his supplying himself with the needed tools. On an order from the Bureau these were obtained. There remained the question of his maintenance for the week, or until his first wages came in. Of the ten dollars furnished by the state, only five dollars remained, and what with the cost of overalls, room rent, food, etc., this sum would not carry him far. Contrary to his usual practice of celebrating his freedom by getting gloriously drunk, he had not touched liquor thus far and purposed to abstain from it as long as possible. It was arranged that he should notify us on the following day as to when his first wage-payment would be due and that we would assist with food and lodging so far as needed. When D. failed to be heard from at the appointed hour, inquiry at the factory disclosed that he had actually begun work, but that his foreman had found his workmanship "too poor to bother with" and had promptly discharged him. Determined efforts made by us to locate D., in order to place him in a shoe factory of less exacting standards, produced no clues as he had apparently registered at the Mills Hotel under an assumed name. For two weeks nothing was seen or heard of him and his return was about to be despaired of when the following letter was received. If, as has since become apparent, this spontaneous communication is to be the beginning of a correspondence, it throws a remarkable light on the strength of the personal and moral tie which even our brief contact with this man had succeeded in establishing.

"NEW HAVEN, CONN., June 24, 1918.

Dear Sir:

I think you will be surprised to hear from me, but nevertheless, I am writing to let you know that I am not as cheap as you have thought me. The fact is I saw I was too weak to make good at the job you were kind enough to get me over at H———'s shoe place in Brooklyn and I left it after trying for about one and a half hours. I came here to some friends that I knew and they have gotten me a job. As to the tools that I got from you, I will send you the price of them as soon as I earn it. Say in two weeks or so. I hope that will be alright. I could not bear to be watched like I was over at H———'s factory. The short time I was in there the foreman Mr. R——— came over to my bench at least twenty times and I got so rattled I could not do any work so I left.

I am very sorry it had to be so. I would like to have had stayed there. I am better off, just now. Don't think I went back to the graft, not me. I am done. As the saying is never again for me. I am well and happy and working every day making an honest living so I am all right now. With best of good wishes for the success of the Social Service Bureau, I remain as ever,

Yours Respt.

J——— D———

I would like to hear from you.

P. S. My present address is

This is my right name.

Mr. J——— P. F———
59 ——— St.,
New Haven, Conn.
care of Mrs. S———"

A., a young man of twenty-three, of Russian-Jewish descent, has already served a term at Elmira and one at Sing Sing. Upon release from the reformatory he was apprenticed to a large newspaper office to work in the composing room at an initial wage of six dollars per week. He did this for a few months and then left, unwilling to submit to the deprivations of a prolonged apprenticeship with its small pay and slow rate of promotion. For a short period he again resorted to theft before being apprehended and committed to prison. There he improved his time by working in the print-shop and subsequently electing the course in the automobile school conducted by the Mutual Welfare League. Examination at the Clinic before discharge showed him to be of a highly nervous disposition, marked by slight tics and tremors, general restlessness, poor concentration, some incoherence in speech; but general intelligence and learning ability were average and better. It was ascertained that he had been using coffee and tea to excess and was also addicted to much cigarette smoking. The injurious effect of these drugs was pointed out to him and other hygienic suggestions imparted by the Director. The prognosis of his case was dubious, despite his avowed intention to "straighten out" and develop into a mechanic.

With some personal effort it was possible to place A. as a mechanic's helper in a commercial automobile school, where he could extend his knowledge and skill in repair work while earning a weekly wage of $15. After three weeks of entirely satisfactory service in this establishment he was assigned, for the employer's convenience, to devote a considerable part of his time to porter work about the building. To this he objected as inconsistent with the terms of his employment as he had understood them. His resignation was accordingly accepted for the end of the month, without raising any hard feelings on either side. In the meantime A. kept the Secretary informed as to his situation, and machinery was set in motion to provide for him appropriate employment elsewhere. As he then expressed a preference for the opportunity to operate a linotype machine, although he was quite out of practice, he was delighted when we found for him such a position at an initial wage of $19 per week. He took up this work without more than a day's intermission between jobs and is at present facing the future with the confidence of being securely started on a skilled mechanic's career. His nervous symptoms have practically disappeared and his general health and bearing are greatly improved, in consequence, he believes, of adopting the Director's parting advice as to his personal habits. Doubtless, also, something is due to the incentives to regular living which his new industrial outlook and his residence and responsibilities at home supply.

W. is a seasoned gangster, who narrowly escaped a sentence of from twenty years to life as an habitual criminal, by accepting the offer of leniency should he plead guilty rather than stand trial, thus escaping with a sentence of three and one half years. He is a man of powerful build and capable of heavy manual labor. But his past manner and standard of life had accustomed him to spend rather freely the money he amassed so easily, and he was hardly prepared to sacrifice willingly those luxuries which only a liberal income could place within his reach. As he had worked on the prison farm and knew how to operate a tractor, it was agreed that he should take employment for the season on a farm at wages of from $50 to $60 per month. Such a position was indeed procured for him in Connecticut but he held it only for a few days, owing to the poor housing accommodations and the food served. He only reported these facts to us after having found work as a truck-driver for a Brooklyn packing-house, where, by working overtime, he could earn about $50 per week. The irregular and excessive hours required of him, however, deprived him of needed sleep and recreation, and upon his request we found for him similar employment—loading beef at the docks—at reasonable hours and at wages of 77 cents per hour. The prospect of substantial savings at this period of unusual reward for labor so appeals to his imagination now that he is content to renounce all his former dissipations, to work to the limit of his strength during the day, and to spend his evenings quietly within the family circle. The metamorphosis, if permanent, is striking. It is interesting to note in this connection that on two or three occasions recently, W. has been stopped on his way to and from work by detectives who challenged him to prove that he was bound on legitimate business. After finally complaining to the police of this treatment, he has not been further molested.

In our relations with the man who comes to us at the time of release, we endeavor first of all to form an estimate of the quality of his motives and the character of his intentions with reference to the future. We further aim at a preliminary understanding of his psychic and physiological make-up with special reference to such constitutional peculiarities, deviations and defects as may be expected to handicap efforts at rehabilitation. By discussing with the individual his peculiar disabilities, hazards and aptitudes in the light of his own history as obtained from him, we are usually able to work out with him some tentative plan of action in which he agrees to cooperate. It is not too much to claim that by virtue of the inclusive and enduring character of our interest in the individual ex-prisoner, the distinctive feature of this after-care effort and that which bids fair to produce for it a unique type of result is this scientific, because essentially human, quality of our dealings with the men we serve. Their past contacts with public and especially legal agencies have been so largely impersonal, autocratic, or even hostile, that many of these men have adopted by way of defensive reaction a suspicious or parasitic and predacious attitude toward the charitable organizations analogous to the popular attitude toward the soulless corporation. In order to break down so far as possible any tendency to exploit the Bureau it is necessary first of all to make the relationship intensely personal, to insist upon complete frankness and beyond that to guard against the temptation to give any manner of material assistance without reasonable assurance that the recipient does at the same time undertake a corresponding obligation. If, in a given case, material relief is to be granted, this should take the form of a loan and be given subject to some form of security. When a position is obtained for a man, his own preference as to kind and conditions of employment having been previously consulted, and his consent given to the particular situation in view, he is held accountable for meeting the employer in person, reporting back the result of the interview, and continuing in communication with the Bureau throughout the process of reestablishment. It is this mutuality of obligation, involving on our part unsparing personal effort in behalf of the man who evinces the disposition to cooperate and on his part the determination to the extent of his ability to carry his own share of the burden, that insures that our intervention in the case shall be morally as well as materially justified.

While no fixed rules of general applicability can be laid down for the guidance of a worker in this field, some provisional principles are suggested by our observation and practice thus far. In judging the sincerity of a prisoner's purpose on discharge, the fact of his spontaneous application to the Bureau is in itself not without significance, as he is under no legal compulsion to accept any degree of supervision. Hitherto, it is true, only a minority of eligible men have taken this initiative. Once at liberty, the behavior of the individual in relation to the Bureau and to his environment generally, in so far as it comes under observation, should soon reveal his characteristics and capacities as no clinical examination can do. His truthfulness of statement, the manner in which he keeps his promises and appointments, his seriousness and persistence in quest of employment, his bearing as a workman, his budget, his willingness to subordinate present gratification to future advantage or permanent good, etc.—these are some of the practical criteria found helpful by us in forecasting the individual ex-prisoner's capacity for successful rehabilitation, and in adjusting the course of treatment. Within varying limits, indeed, it is possible to train the individual to respond more adequately to the requirements of his life situation; but in the absence of closer supervision and discipline than it is now feasible for the Bureau to provide, those limits are rather narrowly drawn. In cases in which the inadequacy is symptomatic of mental deficiency or other fixed pathological deviation, educational efforts of this type are apt to prove ultimately unavailing.

In conclusion, may I say a word as to the future development of this after-care service so auspiciously begun and already regarded as a boon by the men within the walls? It is recommended that, pending the acquisition by the Bureau of a staff of professionally trained, paid field workers to assist the executive secretary in the discharge of the rapidly expanding work with discharged prisoners, a staff of volunteers be recruited in the various racial, religious and neighborhood groups of the city. These should first be subjected to a more or less rigorous selective process, by means of which their personal and temperamental traits, their interests and other qualifications would be disclosed. Those found to be adapted to the work would then be paired off with individual men from prison on the basis of a similar scrutiny of their peculiar make-up and situation and in strict accordance with the principle of mutual helpfulness. The assignment should be made with the utmost care and discretion at the outset, but errors of judgment subsequently discovered should be promptly rectified. The volunteers or "big brothers" should report individually at stated intervals to the executive secretary and receive suggestions from him. They should also meet collectively as a committee or round-table to exchange experiences and reflections.

In addition to this group, whose function it will be to facilitate the re-absorption of the individual from prison into the general community, it is suggested that another committee be formed, composed of representatives of the prison community, the Mutual Welfare League. The confidence of the prisoners themselves in the Social Service Bureau and their consequent cooperation with its purposes is obviously a fundamental condition of its largest usefulness. Such representation in the structure of the organization as is here proposed would go a long way toward enlisting such active support, creating new bonds of mutual understanding and stimulating an intelligent interest in the problems of the Bureau which so closely concern every man looking forward to his release from prison walls. This responsible participation on the part of the League should react in a vitalizing manner upon the educational and other reconstructive endeavors as carried on within the institution. Incidentally it would in time demonstrate to the state authorities the necessity of providing out of public funds more adequate facilities for the industrial and general training of inmates. And finally, it would prepare the way for a complete new orientation in prison management, assigning to the processes of reconstruction and rehabilitation a central place with all other functions subsidiary.

ANNUAL CENSUS OF THE INSANE, FEEBLEMINDED, EPILEPTICS AND INEBRIATES IN INSTITUTIONS IN THE UNITED STATES, JANUARY 1, 1918

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WITH the cooperation of the institutions caring for the classes herein enumerated, The National Committee for Mental Hygiene presents its second annual census of the insane, feebleminded, epileptics and inebriates in institutions in the United States. The publication of the census, which was taken January 1, 1918, has been delayed by the difficulty experienced in getting reports from a few institutions. The great majority of the institutions, however, responded promptly, and willingly supplied all the data requested.

In addition to the enumeration of the classes mentioned, this study shows, with reference to the state hospitals, the admissions, deaths, patients on parole and per capita cost of maintenance for the preceding fiscal year, which in most of these hospitals ends on June 30 or September 30.

Reports were received from 575 institutions, classified as follows:

1. Number of institutions represented	575
a. Public	346
b. Private	229
2. Public institutions for insane	
a. State hospitals	155
b. Federal hospitals	2
c. County or city institutions (not including those for temporary care)	115
d. Institutions for temporary care	17
3. State institutions for feebleminded	30
4. State institutions for feebleminded and epileptics	9
5. State institutions for epileptics	11
6. State institutions for inebriates	3
7. City institutions for feebleminded	1
8. City institutions for inebriates	1

9. Private institutions

a. Having insane only	49
b. Having feebleminded only	33
c. Having epileptics only	4
d. Having inebriates only	17
e. Having more than one of these classes	126

No attempt was made to secure data from almshouses, penal or reformatory institutions.

CENSUS OF PUBLIC AND PRIVATE INSTITUTIONS

INSANE

(See Table I, page 95.)

On January 1, 1918, there were 239,820 insane patients under treatment in institutions in the United States. Of these, 231,048 were in public institutions and 8,772 in private hospitals. Compared with the census of January 1, 1917, there was an increase during the year of 6,406 patients in the public institutions and of 541 in the private, a total increase of 6,947. Of the 231,048 patients in public institutions, 207,705 were cared for in state hospitals; 22,443 in county or city institutions, and 900 in institutions for temporary care. The increases during the year in these hospitals were 5,681, 586 and 139 respectively.

Sex of Insane under Treatment

Of the 239,820 insane patients under treatment on January 1, 1918, 125,919 were men and 113,901 women. The percentages were 52.5 and 47.5 respectively. In the total population of the United States in 1910 there were 106 males to 100 females. In the institutions for the insane in that year the ratio was 110.8 males to 100 females. The relative proportion of the sexes in the hospitals for the insane has shifted but little during the interval of eight years, as the ratio shown by the present census is 110.55 males to 100 females.

The sex distribution of the insane under treatment in the several states varies widely. The women outnumber the men in some of the eastern and southern states while the men are greatly in excess in most of the western states. The following comparisons show some of the largest differences in ratios:

Comparisons of sex distribution of insane under treatment in institutions, January 1, 1918

State	*Number of males to each 100 females*
Arizona	270.6
California	142.3
Georgia	91.0
Idaho	159.3
Illinois	116.5
Kansas	122.4
Kentucky	121.0
Massachusetts	98.1
Minnesota	137.8
Montana	249.3
New Jersey	90.2
New York	90.3
Pennsylvania	114.5
Tennessee	86.8
Virginia	101.6
Washington	169.5
Wisconsin	125.5

In Massachusetts and New York the patients under treatment represent the accumulation of the past 50 years. The excess of women patients in these states is due to their greater hospital longevity.

In the private institutions the women patients slightly outnumber the men. This condition probably arises from the fact that the economic status of the family is less disturbed by the insanity of the wife than by that of the husband.

Sex distribution of insane in institutions, January 1, 1918

	Number			*Per cent in each class of institution*		
	M.	*F.*	*T.*	*M.*	*F.*	*T.*
Public institutions	121,862	109,186	231,048	96.8	95.9	96.3
State hospitals	109,994	97,711	207,705	87.4	85.8	86.6
County and city institutions	11,402	11,041	22,443	9.0	9.7	9.3
Institutions for temporary care	466	434	900	0.4	0.4	0.4
Private institutions	4,057	4,715	8,772	3.2	4.1	3.7
Total	125,919	113,901	239,820	100.0	100.0	100.0

FEEBLEMINDED

(See Table II, page 97.)

The census shows a total of 39,381 feebleminded persons in institutions throughout the country. Of these, 36,277 were in public and 3,104 in private institutions. Compared with the census of January 1, 1917, there was an increase during the year of 2,279 inmates in the public and 288 in the private institutions, a total increase of 2,567. Of the 36,277 feebleminded persons in public institutions, 32,789 were cared for directly by the state and 3,488 were under county or city care.

Sex of Feebleminded in Institutions

Of the 39,381 feebleminded persons under treatment on January 1, 1918, 19,731 were males and 19,650 females. In the state institutions there were 16,123 males and 16,666 females. In the other public institutions there were 1,849 males and 1,639 females. In the private institutions there were 1,759 males and 1,345 females. It will be noted that there is much less disparity between the sexes in these totals than was seen in the totals of the insane under treatment. While the ratio of the two sexes of the feebleminded varies considerably in the several states the variation seems much less of a sectional matter than was the case with the insane.

A detailed examination of the census indicates the fact that institutional care of the feebleminded is not well developed in several states. In Alabama and Georgia there are no feebleminded in state institutions. In Arizona, Arkansas, Delaware, Florida, Idaho, Louisiana, Mississippi, New Mexico, Nevada, South Carolina, Tennessee, Utah and West Virginia, the feebleminded are cared for in state hospitals for the insane, as no separate state institution is provided for them. The feebleminded in many other states are cared for both in separate institutions and in state hospitals for the insane. In no state does the provision for the feebleminded equal that made for the insane.

Private institutional care of the feebleminded, while less extensive than that of the insane, is relatively farther advanced than public institutional care. In New Jersey there were 554 feebleminded persons in private institutions; in New York, 352; in Pennsylvania, 1,126; and in Wisconsin, 292. As much thought is now being given to the proper care of the feebleminded, it is probable that in the near future institutions for this class will be greatly expanded.

Sex distribution of feebleminded in institutions, January 1, 1918

	Number			*Per cent in each class of institution*		
	M.	*F.*	*T.*	*M.*	*F.*	*T.*
Public institutions..	17,972	18,305	36,277	91.1	93.2	92.1
State...........	16,123	16,666	32,789	81.7	84.8	83.3
Other...........	1,849	1,639	3,488	9.4	8.4	8.8
Private institutions.	1,759	1,345	3,104	8.9	6.8	7.9
Total.........	19,731	19,650	39,381	100.0	100.0	100.0

EPILEPTICS

(See Table III, page 98.)

The epileptics in institutions in the United States on January 1, 1918, exclusive of those epileptics that were insane or feebleminded, numbered 11,944. Of these, 11,393 were in public and 551 in private institutions. Compared with the census of January 1, 1917, there was an increase during the year of 999 epileptics in public institutions and of 144 in private institutions. Of the 11,393 patients in public institutions 10,442 were cared for by the state and 951 by counties and cities. It is a well-known fact that only a small proportion of the total number of epileptics is cared for in institutions of any kind.

Sex of Epileptics in Institutions

Of the 11,944 epileptic patients under treatment January 1, 1918, 6,643 were males and 5,301 females. The percentages were 55.6 and 44.4 per cent respectively. The excess of males is not to be construed as indicating greater prevalence of epilepsy among males than females, but, rather, that a larger proportion of the epileptic males have been placed under institutional care. The disparity in the two sexes in some states is very great. For example, in Indiana there are 372 epileptic males in institutions and only 25 females. Private institutional care of epileptics has not attained large proportions in any state in the Union; 189 private cases are reported in Pennsylvania; 74 in Massachusetts; 76 in Missouri and 51 in New York.

Sex distribution of epileptics in institutions, January 1, 1918

	Number			Per cent in each class of institution		
	M.	*F.*	*T.*	*M.*	*F.*	*T.*
Public institutions....	6,390	5,003	11,393	96.2	94.4	95.4
State..............	5,822	4,620	10,442	87.6	87.2	87.4
Other..............	568	383	951	8.6	7.2	8.0
Private institutions...	253	298	551	3.8	5.6	4.6
Total...........	6,643	5,301	11,944	100.0	100.0	100.0

INEBRIATES

(See Table IV, page 99.)

The inebriates under institutional care in the several states on January 1, 1918, numbered 3,565. Of these, 2,840 were in public and 725 in private institutions. Compared with the census of January 1, 1917, there was a decrease of 1,151 in public institutions and 175 in private institutions, a total decrease of 1,326, or 37.2 per cent. The figures give conclusive proof that inebriety is a decreasing rather than a growing evil in this country.

Sex of Inebriates in Institutions

Of the 3,565 inebriates under treatment, 2,658 were males and 907 females. The excess of males indicates to an extent at least, the greater prevalence of inebriety in the male sex. It is probable, however, that the disparity of the sexes in inebriety is even greater than the figures indicate.

The wide variation in the number of inebriates cared for in the several states is partly due to the lack of institutions for inebriates in some states and partly to the lack of inebriates in others. It is noteworthy that only in California and in Massachusetts does the total number of inebriates cared for in state institutions reach 100, while *other* public institutions for inebriates care for 700 in Maryland; 157 in New Jersey; 136 in New York and 350 in Pennsylvania. A few inebriates are under private institutional care in nearly every state of the Union but in no instance does the number so cared for reach 100.

Sex distribution of inebriates in institutions January 1, 1918

	Number			Per cent in each class of institution		
	M.	F.	T.	M.	F.	T.
Public institutions	2,161	679	2,840	81.3	74.9	79.7
State	1,004	245	1,249	37.8	27.0	35.1
Other	1,157	434	1,591	43.5	47.9	44.6
Private institutions	497	228	725	18.7	25.1	20.3
Total	2,658	907	3,565	100.0	100.0	100.0

INCREASE OF INSANE IN INSTITUTIONS COMPARED WITH INCREASE OF THE GENERAL POPULATION.

(See Table V, page 100.)

Federal censuses of the insane in institutions, separate from the insane outside of institutions, were taken in 1880, 1890, 1904 and 1910. Previous to 1880 the censuses of the insane were incomplete and the data relating to the insane in institutions were not separately compiled. The only other data available previous to the present census were those of the census taken on January 1, 1917, by The National Committee for Mental Hygiene.

The growth of institutional care of the insane is clearly depicted by the comparison of the results of these censuses.

Insane in institutions, 1880–1918

Year	Number	Per 100,000 of general population
1880	40,942	81.6
1890	74,028	118.2
1904	150,151	183.6
1910	187,791	204.2
1917	232,873	226.5
1918	239,820	229.6

Table V compares the totals by sex of the patients under treatment in the several states in 1910 and 1918, and the percentages of increase of the insane and general population in each state. The percentage of increase of the general population during the eight years was 13.6 and of the insane in institutions 27.7. The percentage of insane in institutions increased faster than that of the general population in all of the states except Idaho, Kansas, New Mexico, Mississippi, Nevada and Vermont. In the last three states there was a decrease in the number of patients in institutions.

The states showing greatest disparity in relative increase of insane and of general population were:

Per cent of increase, 1910–1918

State	*Insane in institutions*	*General population*
Arkansas	45.4	13.0
Florida	48.8	23.2
Illinois	36.4	11.3
Indiana	26.0	5.3
Kentucky	26.6	4.9
Minnesota	30.8	12.2
Missouri	24.9	4.4
Montana	73.9	27.5
North Dakota	87.1	34.9
Texas	42.8	17.0
Utah	70.5	20.2

In most of these states the marked increase of the insane in institutions is due to the additional provision for their care made during the past eight years.

No great difference is shown in the relative increase of the two sexes.

INSANE IN INSTITUTIONS BY DIVISIONS AND STATES 1910, 1917 AND 1918

(See Table VI, page 101.)

The rate of insane in institutions per 100,000 of general population increased from 204.2 in 1910 to 226.5 in 1917 and 229.6 in 1918. The accompanying tabulation gives a general view of the increase in the several divisions.

Insane in institutions in the several divisions of the United States per 100,000 of population in 1910, 1917 and 1918

Division	*Rank*	*Number per 100,000*		
		1910	*1917*	*1918*
New England	1	298.8	326.7	330.6
Middle Atlantic	2	271.2	296.9	296.5
East North Central	4	226.0	251.1	255.7
West North Central	5	194.9	219.8	230.8
South Atlantic	6	163.6	185.0	186.3
East South Central	8	116.0	124.9	123.2
West South Central	9	95.8	104.6	112.8
Mountain	7	135.7	148.8	155.5
Pacific	3	243.4	283.8	277.4

Referring to the above figures it will be seen that an increase in rate occurred in each division during the years 1910 to 1917, but during the year 1917 there was a decrease in rate in four of the nine divisions. The rank of the several divisions was the same in 1918 as in 1910.

The states having a lower rate of insane in institutions per 100,000 in population in 1918 than in 1910 were Idaho, Kansas, Mississippi, Nevada, New Mexico and Vermont. The rates for these states at the time of the two censuses were:

State	*Number per 100,000* *1910*	 *1918*
Idaho	119.2	110.9
Kansas	172.2	164.9
Mississippi	110.1	81.0
Nevada	280.9	195.1
New Mexico	66.9	61.3
Vermont	278.1	267.5

The changes in rate since 1910 in the states having the highest rate of insane under treatment in 1918 were as follows:

State	*Number per 100,000* *1910*	 *1918*
California	279.8	322.7
Connecticut	321.1	336.6
Iowa	241.7	329.7
Maryland	248.6	284.1
Massachusetts	344.6	384.0
New York	343.2	375.3
Wisconsin	282.2	305.2

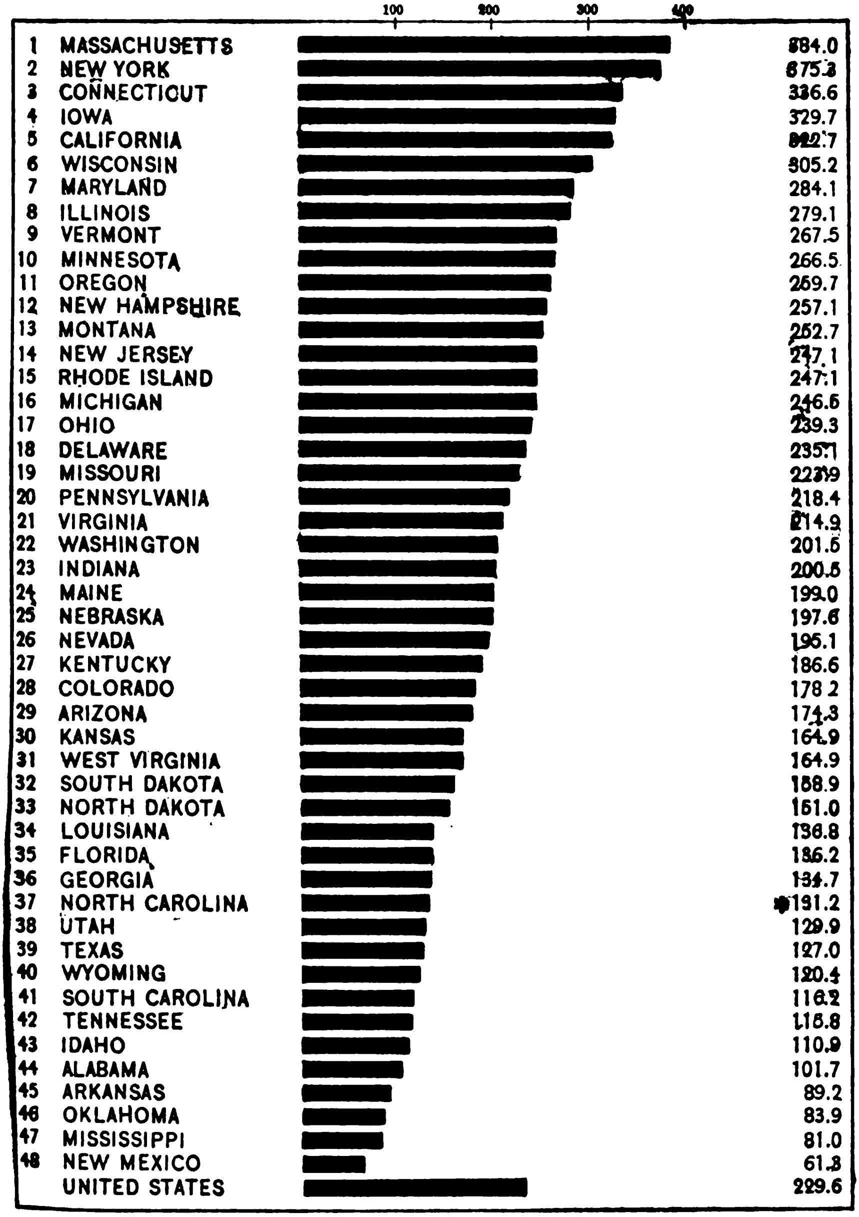
It should be borne in mind that these figures do not indicate unusually high rates of insanity, but, rather, that a larger proportion of the total number of the insane in these states is being cared for in institutions.

GROWTH OF INSTITUTIONAL CARE OF THE FEEBLEMINDED IN THE SEVERAL STATES SINCE 1910

(See Table VII, page 103.)

It is well known that only a small part of the feebleminded of the country are cared for in institutions. During the past few years general studies have aroused public sentiment relative to the care of the feebleminded, and new institutions for this class are being planned and constructed. Although building operations were greatly retarded during the war period, the feebleminded in institutions in the United States increased from 20,731 in 1910 to

INSANE IN INSTITUTIONS IN THE UNITED STATES PER 100,000 OF GENERAL POPULATION ON JANUARY 1, 1918



1	MASSACHUSETTS	384.0
2	NEW YORK	375.3
3	CONNECTICUT	336.6
4	IOWA	329.7
5	CALIFORNIA	322.7
6	WISCONSIN	305.2
7	MARYLAND	284.1
8	ILLINOIS	279.1
9	VERMONT	267.5
10	MINNESOTA	266.5
11	OREGON	259.7
12	NEW HAMPSHIRE	257.1
13	MONTANA	252.7
14	NEW JERSEY	247.1
15	RHODE ISLAND	247.1
16	MICHIGAN	246.5
17	OHIO	239.3
18	DELAWARE	235.1
19	MISSOURI	228.9
20	PENNSYLVANIA	218.4
21	VIRGINIA	214.9
22	WASHINGTON	201.5
23	INDIANA	200.5
24	MAINE	199.0
25	NEBRASKA	197.6
26	NEVADA	195.1
27	KENTUCKY	186.6
28	COLORADO	178.2
29	ARIZONA	174.3
30	KANSAS	164.9
31	WEST VIRGINIA	164.9
32	SOUTH DAKOTA	158.9
33	NORTH DAKOTA	151.0
34	LOUISIANA	136.8
35	FLORIDA	136.2
36	GEORGIA	134.7
37	NORTH CAROLINA	*131.2
38	UTAH	129.9
39	TEXAS	127.0
40	WYOMING	120.4
41	SOUTH CAROLINA	116.2
42	TENNESSEE	115.8
43	IDAHO	110.9
44	ALABAMA	101.7
45	ARKANSAS	89.2
46	OKLAHOMA	83.9
47	MISSISSIPPI	81.0
48	NEW MEXICO	61.3
	UNITED STATES	229.6

* Not including Hospital for the Dangerous Insane

39,381 in 1918. From 1917 to 1918 the increase was 2,567. Now that the war is over we may expect a still greater movement in the erection of homes for the mentally defective. Reference to Table VII will show that there are feebleminded in institutions in every state in the Union except Alabama, and that the number in every other state except Utah increased during the eight years from 1910 to 1918. Some of the most noteworthy increases were:

	Increase of feebleminded in institutions, 1910 to 1918	
State	*Number*	*Per cent*
California	607	71.1
Illinois	1,067	84.3
Iowa	639	53.7
Maryland	803	259.0
Massachusetts	1,660	113.4
Michigan	848	86.0
New Jersey	835	130.5
New York	2,389	69.8
Ohio	693	45.4
Pennsylvania	1,982	73.3
Wisconsin	627	60.9

Slight decreases in the number under treatment occurred in several states during the year 1917. It is probable, however, that these figures were incidental and do not represent a change in the trend of the movement for the better care of the feebleminded.

PATIENTS ON PAROLE FROM STATE HOSPITALS FOR THE INSANE, JANUARY 1, 1918

(See Table VIII, page 104.)

The laws of the several states providing for the parole of patients from hospitals for the insane differ so greatly that exact comparisons of conditions with respect to the parole of patients are impossible. In some states the parole period is limited to three months; in others to six months and in others to one year or longer. In Arkansas patients are permitted to be out on parole one year. At the end of that time the period may be extended another year in case application is made for such extension. In Wisconsin the law states that "The superintendents of the state hospitals and of the Milwaukee County Hospital may permit an inmate to go at large on parole, when in their opinion it is safe and proper to do so. If within two years it becomes unsafe to allow such person to remain at large any longer, the superintendent must require his return to the hospital, unless he has been adjudged sane by competent authority." It will be noted that an exceptionally high percentage of the insane patients of Arkansas and Wisconsin are reported on parole. The other states reporting more than ten per cent of the insane patients on parole with the number and percentage in each instance are given herewith:

Patients on parole in certain states

State	*Number*	*Per cent on parole*
Alabama	320	13.2
Idaho	52	10.3
Iowa	608	13.1
Kansas	360	11.9
Massachusetts	1,771	12.5
Minnesota	663	10.8
Montana	146	12.0
North Carolina	366	11.6
North Dakota	137	11.7
Rhode Island	288	20.2
Texas	709	12.6
Virginia	791	16.6
Washington	336	10.3
West Virginia	248	10.5

ADMISSIONS OF INSANE PATIENTS TO STATE HOSPITALS IN 1910 AND 1917

(See Table IX, page 105.)

Table IX shows the admissions by sexes to the state hospitals for the insane in each state in the years 1910 and 1917, and gives the rate of admissions per 100,000 of general population in the two years. In 1910 there were 26,191 males and 19,603 females admitted to the state hospitals for the insane making a total of 45,794. In 1917, the numbers were 36,111 males and 26,787 females, a total of 62,899. The male admissions increased 37.9 per cent, the females 36.6 per cent and the total admissions 37.3 per cent.

The ratio of females to males was 100 to 133.6 in 1910; and 100 to 134.8 in 1917. The rate of all admissions per 100,000 of the general population was 49.8 in 1910, and 60.7 in 1917. The following table presents a comparison of the rates in 1910 and in 1917 in the states having the highest rate in the latter year.

State	*Number of admissions per 100,000 of population*	
	1910	*1917*
California	75.4	85.7
Connecticut	61.5	80.9
Illinois	46.9	109.2
Massachusetts	117.1	151.6
Minnesota	67.7	83.0
Montana	73.9	124.8
New York	85.9	97.3

In marked contrast to these are the rates of those states which show a decrease in rate of admissions in 1917.

State	*Number of admissions per 100,000 of population*	
	1910	*1917*
Arizona	66.1	65.2
Delaware	62.8	55.3
Idaho	62.3	48.3
Indiana	42.2	39.9
Iowa	45.8	43.9
Maine	68.6	58.9
Nevada	68.4	67.7
North Carolina	37.3	32.0
North Dakota	38.8	33.1
Oregon	87.8	51.6
South Dakota	34.1	33.2
Texas	32.5	26.3
Washington	77.4	57.7
West Virginia	40.5	34.2
Wisconsin	48.0	45.7

It is difficult to understand why there should be such marked differences in the rate of admissions in the several states and why the rate should rapidly increase in one state and decline in another.

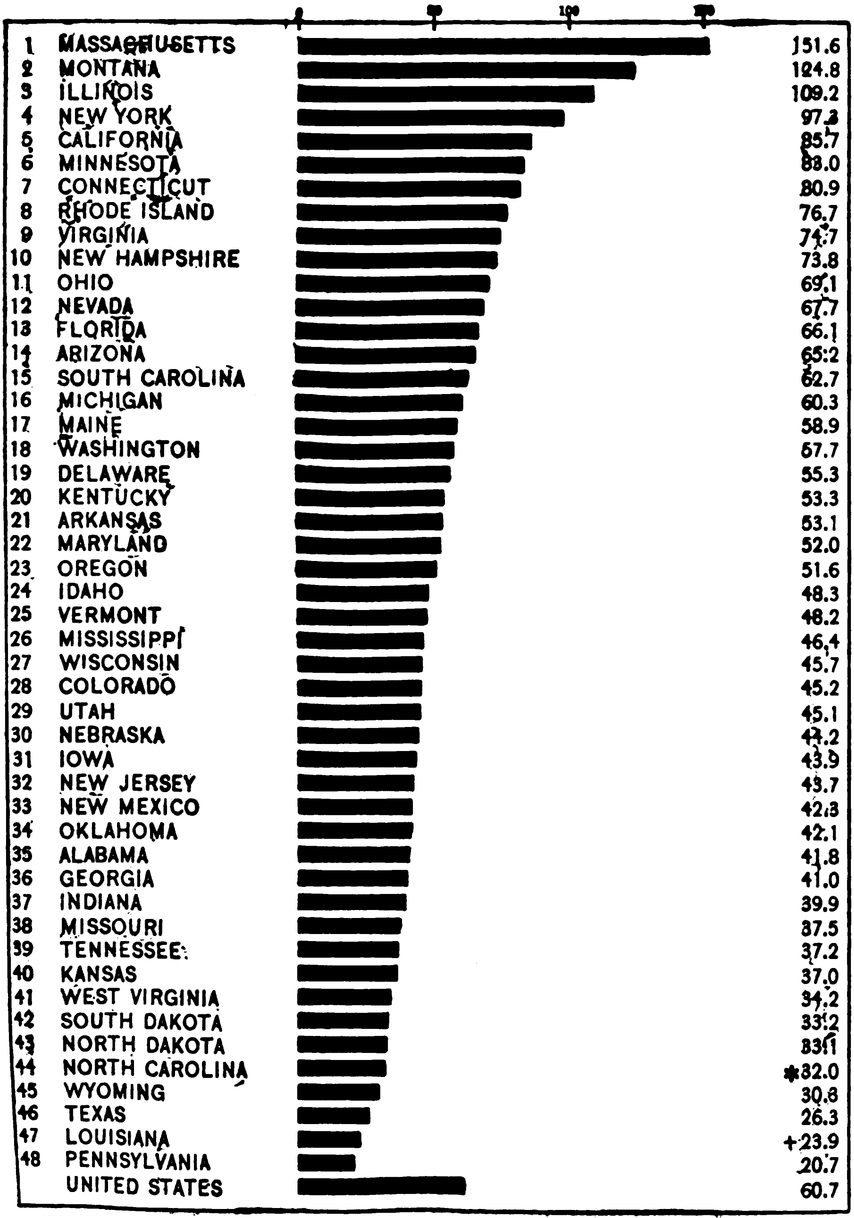
It is noteworthy that the increase in rate of admissions is greater in the states that make liberal provision for the insane and that care for nearly all of the insane in state hospitals.

DEATHS OF INSANE PATIENTS IN STATE HOSPITALS IN 1910 AND IN 1917

(See Table X, page 106.)

The deaths occurring in the state hospitals for the insane increased from 15,476 in 1910, to 23,509 in 1917. The death rate per 1,000 patients under treatment at the beginning of the year increased from 97 in 1910, to 116 in 1917. The deaths among the males increased from 9,117 in 1910, to 13,792 in 1917, the rates

ADMISSIONS OF INSANE PATIENTS TO STATE HOSPITALS IN THE UNITED STATES PER 100,000 OF GENERAL POPULATION DURING THE FISCAL YEAR 1917



* Not including Hospital for the Dangerous Insane + Estimated

in the two years being 108 and 129 respectively. The deaths among the females increased from 6,359 in 1910, to 9,717 in 1917. The death rate among the females increased from 85 to 99. The higher death rate among the males is largely due to the greater prevalence of general paralysis in the male sex. Studies in the New York hospitals have shown that the average hospital life of the patients with general paralysis, who die in the hospitals, is approximately 1.2 years.

The marked increase in the death rate seen in the comparison of the rates of 1910 and 1917 is partly due to the accumulation of old cases in the hospitals and partly to unfavorable conditions existing in 1917. In the New York state hospitals the death rate in 1917 was the highest in the history of the state hospital system.

In comparing the death rates in the hospitals of the several states many factors have to be taken into consideration, among which are the sex, age, and physical and mental condition of the patients under treatment. Some state hospitals admit only acute cases while others receive incipient as well as advanced cases of all types of mental disorder. Moreover, some hospitals are very much better equipped than others to treat both mental and physical diseases. If all the hospitals were operating under like conditions with respect to admissions, medical and nursing force, equipment and financial support, the death rate might properly be taken as an index of efficiency.

COST OF MAINTENANCE OF PATIENTS IN STATE HOSPITALS AND AVERAGE DAILY PATIENT POPULATION FOR THE FISCAL YEAR OF 1917

(See Table XI, page 107.)

Table XI represents the first attempt to show the per capita cost of maintenance of the patients in the state hospitals in the several states. The cost of maintenance as given in the table includes all expenditures for the care of patients except extraordinary repairs, new construction and permanent improvements. The total cost of maintenance of insane patients in the state hospitals in the fiscal year 1917 was $43,926,888.88. The average per capita cost based on the average daily patient population was $207.28. The highest per capita cost, $306.97, was reported by the State of Maine; the lowest, $135.90 by the State of Virginia.

In general the southern and western states have lower per capita costs than the northern and eastern. The higher costs in the latter sections are partly due to higher fuel cost and partly to the higher rate of wages prevailing in these sections. The difference in standards of care is also a large element in determining difference in per capita cost.

NEW INSTITUTIONS

Since the publication of the 1917 census of institutions caring for the insane, feebleminded, epileptics and inebriates,* several new institutions have been completed. The Alton State Hospital, founded in 1911, the ninth state hospital in Illinois, was opened in July, 1917; the Texas Colony for the Feebleminded, established in 1915, received its first charges October 30, 1917; the Iowa State Hospital and Colony for Epileptics, at Woodward, authorized in 1914, was opened on September 3, 1917; and the Dixon State Colony, Illinois, created by legislative enactment in 1913, was opened to receive epileptics, May 1, 1918.

The Willmar State Asylum, Minnesota, opened in December, 1912, as a state hospital for inebriates, became in 1917 by an act of the legislature a state hospital for the insane—the sixth in the state. The 1917 legislature of Connecticut enacted a law which consolidated the Connecticut Colony for Epileptics, located at Mansfield, and the Connecticut Training School for the Feebleminded, at Lakeville, into one institution called the Mansfield State Training School and Hospital. The State Colony for Feebleminded Males, at New Lisbon, New Jersey, formerly the Burlington County Colony, which was established in 1914 and was under the direction of The Training School (Vineland), was taken over by the state in 1917. This is the second state institution for the feebleminded in New Jersey, the first one, established in 1888, caring for feebleminded females.

Pennsylvania and Texas have each recently authorized two additional hospitals for the insane. In the former, one hospital to be known as the Eastern Hospital for the Insane was authorized by the 1917 legislature; the other, the Western Hospital for the Insane, was established in 1915 and is located near Irwin. The 1917 legislature of Texas enacted laws creating the Northwest Texas Insane Asylum and the Hospital for Negro Insane. Wichita Falls has been selected as a site for the former, while the latter is located at Rusk on property held by the state and used in part as a penitentiary. Texas has three other state hospitals for the insane.

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*MENTAL HYGIENE, vol. 1, 548–66, October 1917.

At the time of writing this report, in fifteen states the feebleminded were not maintained in separate state institutions, but in state hospitals for the insane, in local public hospitals or in private institutions; in one state, as previously noted, no feebleminded were reported. It is a hopeful sign however, that many state institutions for the feebleminded have recently been established. In 1917 the legislatures of Arkansas, California and Delaware each authorized the establishment of an institution for the feebleminded. In 1918 the Kentucky and South Carolina legislatures took like action; in the former a "Farm Colony for the Feebleminded" was created and the name of the existing institution for the feebleminded was changed to the "Training School for the Feebleminded," the two institutions together to be known as the "State Institution for the Feebleminded." The Pennsylvania Village for Feebleminded Women, at Laurelton, authorized in 1913, and the School for Feebleminded at Belchertown, Massachusetts, authorized by the 1915 legislature, will soon be ready to receive pupils. The Idaho State Sanitarium, established by the 1913 legislature for the care of both feebleminded and epileptics, will probably be opened in the near future. The Southern Wisconsin Home for Feebleminded and Epileptics, at Union Grove, which was established in 1913, is now ready for occupancy.

Such increased institutional provision for the insane, feebleminded and epileptics during the recent period of great stress, and the active interest in the feebleminded now being shown in a number of states, particularly Alabama, Georgia, Illinois, Indiana, Massachusetts, Mississippi, New York, Ohio, Pennsylvania, Tennessee and Washington, indicate that public opinion is now awakening to the need of proper care for these individuals and that further progress may be confidently expected in the near future.

Table I—Insane in institutions in the several states of the Union, January 1, 1918

State	Total			Public									Private		
				State hospitals			County or city institutions			Institutions for temporary care					
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
United States	125,919	113,901	239,820	109,994	97,711	207,705	11,402	11,041	22,443	466	434	900	4,057	4,715	8,772
Alabama	1,151	1,269	2,420	1,151	1,269	2,420	....	....	....	..	..	..	....	....	....
Arizona	341	126	467	341	126	467	....	....	....	..	..	..	....	....	....
Arkansas	779	809	1,588	779	809	1,588	....	....	....	..	..	..	....	....	....
California	5,826	4,095	9,921	5,752	4,004	9,756	....	....	....	22	11	33	52	80	132
Colorado	1,016	769	1,785	956	710	1,666	6	4	10	8	..	8	46	55	101
Connecticut	2,026	2,269	4,295	1,872	1,956	3,828	....	....	....	..	..	..	154	313	467
Delaware	278	230	508	278	230	508	....	....	....	..	..	..	....	....	....
District of Columbia	2,524	868	3,392	2,482	852	3,334	....	....	....	35	7	42	7	9	16
Florida	685	578	1,263	685	578	1,263	....	....	....	..	..	..	....	....	....
Georgia	1,871	2,057	3,928	1,847	2,030	3,877	....	....	....	..	..	..	24	27	51
Idaho	309	194	503	309	194	503	....	....	....	..	..	..	....	....	....
Illinois	9,426	8,089	17,515	9,327	7,951	17,278	....	....	....	50	36	86	49	102	151
Indiana	2,912	2,792	5,704	2,809	2,701	5,510	103	91	194	..	..	..	....	....	....
Iowa	4,013	3,323	7,336	2,648	2,009	4,657	1,193	1,045	2,238	..	..	..	172	269	441
Kansas	1,691	1,381	3,072	1,673	1,362	3,035	....	....	....	..	..	..	18	19	37
Kentucky	2,453	2,027	4,480	2,444	2,011	4,455	....	....	....	..	..	..	9	16	25
Louisiana	1,266	1,294	2,560	1,198	1,121	2,319	....	....	....	20	45	65	48	128	176
Maine	781	771	1,552	773	764	1,537	....	....	....	..	..	..	8	7	15
Maryland	1,882	2,036	3,918	1,351	1,283	2,634	....	....	....	119	134	253	412	619	1,031
Massachusetts	7,235	7,373	14,608	7,077	7,099	14,176	....	....	....	26	36	62	132	238	370
Michigan	4,154	3,521	7,675	3,642	2,870	6,512	370	387	757	26	26	52	116	238	354
Minnesota	3,597	2,610	6,207	3,579	2,580	6,159	....	....	....	..	..	..	18	30	48
Mississippi	756	855	1,611	756	855	1,611	....	....	....	..	..	..	....	....	....
Missouri	4,370	3,331	7,701	2,651	2,218	4,869	911	1,076	1,987	..	..	..	808	37	845

Table I—Insane in institutions in the several states of the Union, January 1, 1918—Continued

State	Total			Public									Private		
				State hospitals			County or city institutions			Institutions for temporary care					
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M	F.	T.	M.	F.	T.
Montana	865	347	1,212	865	347	1,212	....	....	....	..	..	..	....	....	....
Nebraska	1,424	1,126	2,550	1,408	1,098	2,506	....	....	....	..	..	..	16	28	44
Nevada	159	61	220	159	61	220	....	....	....	..	..	..	....	....	....
New Hampshire	551	594	1,145	551	594	1,145	....	....	....	..	..	..	....	....	....
New Jersey	3,570	3,959	7,529	2,289	2,202	4,491	1,270	1,730	3,000	..	..	..	11	27	38
New Mexico	137	127	264	137	127	264	....	....	....	..	..	..	....	....	....
New York	18,796	20,812	39,608	18,358	19,953	38,311	....	....	....	81	70	151	357	789	1,146
North Carolina	1,314	1,900	3,214	1,294	1,868	3,162	....	....	....	..	..	..	20	32	52
North Dakota	743	432	1,175	743	432	1,175	....	....	....	..	..	..	....	....	....
Ohio	6,665	5,879	12,544	6,561	5,722	12,283	....	....	....	12	16	28	92	141	233
Oklahoma	1,103	854	1,957	1,088	842	1,930	....	....	....	..	..	..	15	12	27
Oregon	1,507	766	2,273	1,320	735	2,055	....	....	....	..	..	..	187	31	218
Pennsylvania	10,176	8,889	19,065	5,291	4,232	9,523	4,019	3,657	7,676	67	53	120	799	947	1,746
Rhode Island	820	741	1,561	758	665	1,423	....	....	....	..	..	..	62	76	138
South Carolina	925	995	1,920	925	995	1,920	....	....	....	..	..	..	....	....	....
*South Dakota	677	477	1,154	677	477	1,154	....	....	....	..	..	..	....	....	....
Tennessee	1,245	1,434	2,679	1,021	1,164	2,185	202	247	449	..	..	..	22	23	45
Texas	2,851	2,937	5,788	2,783	2,852	5,635	....	....	....	..	..	..	68	85	153
Utah	314	269	583	314	269	583	....	....	....	..	..	..	....	....	....
Vermont	503	475	978	294	290	584	....	....	....	..	..	..	209	185	394
Virginia	2,408	2,370	4,778	2,396	2,366	4,762	....	....	....	..	..	..	12	4	16
Washington	2,064	1,218	3,282	2,059	1,211	3,270	....	....	....	..	..	..	5	7	12
West Virginia	1,288	1,063	2,351	1,288	1,063	2,351	....	....	....	..	..	..	....	....	....
Wisconsin	4,316	3,439	7,755	879	494	1,373	3,328	2,804	6,132	..	..	..	109	141	250
Wyoming	156	70	226	156	70	226	....	....	....	..	..	..	....	....	....

*Includes Asylum for Insane Indians.

Table II—Feebleminded in institutions in the several states of the Union, January 1, 1918

State	Total			Public						Private		
				State institutions			Other institutions					
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
United States	19,781	19,650	39,381	16,123	16,666	32,789	1,849	1,639	3,488	1,759	1,345	3,104
Alabama	....	....	....	....	....	....	....	....	....	....	....	....
Arizona	2	1	3	2	1	3	....	....	....	....	....	....
Arkansas	129	109	238	129	109	238	....	....	....	....	....	....
California	794	667	1,461	750	627	1,377	40	24	64	4	16	20
Colorado	54	43	97	42	40	82	2	....	2	10	3	13
Connecticut	184	176	360	178	170	348	....	....	....	6	6	12
Delaware	10	12	22	10	12	22	....	....	....	....	....	....
Dist. of Columbia	10	1	11	7	....	7	3	1	4	....	....	....
Florida	87	61	148	87	61	148	....	....	....	....	....	....
Georgia	4	3	7	....	....	....	....	....	....	4	3	7
Idaho	58	24	82	58	24	82	....	....	....	....	....	....
Illinois	1,223	1,109	2,332	1,170	1,063	2,233	....	....	....	53	46	99
Indiana	649	859	1,508	625	843	1,468	23	15	38	1	1	2
Iowa	936	892	1,828	755	755	1,510	155	105	260	26	32	58
Kansas	318	336	654	317	336	653	....	....	....	1	....	1
Kentucky	270	227	497	219	196	415	....	....	....	51	31	82
Louisiana	76	70	146	70	54	124	3	1	4	3	15	18
Maine	190	213	403	189	212	401	....	....	....	1	1	2
Maryland	571	542	1,113	516	510	1,026	50	20	70	5	12	17
Massachusetts	1,703	1,421	3,124	1,663	1,396	3,059	....	....	....	40	25	65
Michigan	919	915	1,834	876	861	1,737	5	7	12	38	47	85
Minnesota	806	652	1,458	788	634	1,422	....	....	....	18	18	36
Mississippi	180	200	380	180	200	380	....	....	....	....	....	....
Missouri	499	507	1,006	339	371	710	125	82	207	35	54	89
Montana	60	41	101	60	41	101	....	....	....	....	....	....
Nebraska	309	262	571	309	262	571	....	....	....	....	....	....
Nevada	2	....	2	2	....	2	....	....	....	....	....	....
New Hampshire	186	169	355	186	169	355	....	....	....	....	....	....
New Jersey	543	932	1,475	46	723	769	95	57	152	402	152	554
New Mexico	9	8	17	9	8	17	....	....	....	....	....	....
New York	2,771	3,039	5,810	1,536	1,880	3,416	1,037	1,005	2,042	198	154	352
North Carolina	65	128	193	64	126	190	....	....	....	1	2	3
North Dakota	117	92	209	117	92	209	....	....	....	....	....	....
Ohio	1,123	1,096	2,219	1,118	1,096	2,214	....	....	....	5	....	5
Oklahoma	287	241	528	287	240	527	....	....	....	....	1	1
Oregon	192	164	356	181	160	341	....	....	....	11	4	15
Pennsylvania	2,453	2,234	4,687	1,619	1,567	3,186	211	164	375	623	503	1,126
Rhode Island	135	174	309	135	174	309	....	....	....	....	....	....
South Carolina	91	53	144	91	53	144	....	....	....	....	....	....
South Dakota	194	151	345	194	151	345	....	....	....	....	....	....
Tennessee	37	50	87	14	15	29	13	27	40	10	8	18
Texas	25	67	92	14	56	70	....	....	....	11	11	22
Utah	26	18	44	26	18	44	....	....	....	....	....	....
Vermont	102	89	191	86	85	171	....	....	....	16	4	20
Virginia	81	226	307	40	177	217	....	....	....	41	49	90
Washington	336	278	614	336	278	614	....	....	....	....	....	....
West Virginia	120	152	272	120	152	272	....	....	....	....	....	....
Wisconsin	750	906	1,656	518	628	1,146	87	131	218	145	147	292
Wyoming	45	40	85	45	40	85	....	....	....	....	....	....

Table III—Epileptics in institutions in the several states of the Union, January 1, 1918

State	Total			Public						Private		
				State institutions			Other institutions					
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
United States	6,643	5,301	11,944	5,822	4,620	10,442	568	383	951	253	298	551
Alabama	....	....	....	....	....	....	..	..	..	..	..	..
Arizona	18	9	27	18	9	27	..	..	..	..	..	..
Arkansas	81	71	152	81	71	152	..	..	..	..	..	..
California	48	24	72	44	17	61	2	6	8	2	1	3
Colorado	6	2	8	....	....	....	..	..	..	6	2	8
Connecticut	105	88	193	96	81	177	..	..	..	9	7	16
Delaware	....	....	....	....	....	....	..	..	..	..	..	..
Dist. of Columbia	5	....	5	....	..	....	5	..	5	..	..	..
Florida	92	58	150	92	58	150	..	..	..	..	..	..
Georgia	1	4	5	....	....	....	..	..	..	1	4	5
Idaho	15	18	33	15	18	33	..	..	..	..	..	..
Illinois	12	7	19	6	4	10	2	..	2	4	3	7
Indiana	372	25	397	360	9	369	12	16	28	..	..	..
Iowa	66	59	125	44	33	77	18	18	36	4	8	12
Kansas	342	236	578	342	236	578	..	..	..	..	..	..
Kentucky	17	30	47	17	30	47	..	..	..	..	..	..
Louisiana	55	56	111	50	46	96	2	1	3	3	9	12
Maine	27	11	38	26	11	37	..	..	..	1	..	1
Maryland	20	43	63	16	16	32	..	..	..	4	27	31
Massachusetts	618	589	1,207	572	561	1,133	..	..	..	46	28	74
Michigan	220	245	465	208	232	440	9	13	22	3	..	3
Minnesota	96	135	231	96	134	230	..	..	..	..	1	1
Mississippi	153	145	298	153	145	298	..	..	..	..	..	..
Missouri	269	294	563	188	172	360	55	72	127	26	50	76
Montana	2	3	5	2	3	5	..	..	..	..	..	..
Nebraska	5	3	8	5	2	7	..	..	..	..	1	1
Nevada	1	2	3	1	2	3	..	..	..	..	..	..
New Hampshire	28	11	39	28	11	39	..	..	..	..	..	..
New Jersey	409	397	806	376	363	739	31	27	58	2	7	9
New Mexico	11	9	20	11	9	20	..	..	..	..	..	..
New York	825	748	1,573	793	726	1,519	1	2	3	31	20	51
North Carolina	128	87	215	126	86	212	..	..	..	2	1	3
North Dakota	29	31	60	29	31	60	..	..	..	..	..	..
Ohio	927	752	1,679	925	750	1,675	..	1	1	2	1	3
Oklahoma	138	101	239	135	100	235	..	..	..	3	1	4
Oregon	28	12	40	20	10	30	..	..	..	8	2	10
Pennsylvania	640	432	1,072	262	193	455	303	125	428	75	114	189
Rhode Island	1	....	1	....	....	....	..	..	..	1	..	1
South Carolina	....	....	....	....	....	....	..	..	..	..	..	..
South Dakota	2	....	2	2	....	2	..	..	..	..	..	..
Tennessee	41	40	81	4	3	7	37	36	73	..	1	1
Texas	306	223	529	301	221	522	..	..	..	5	2	7
Utah	....	....	....	....	....	....	..	..	..	..	..	..
Vermont	39	25	64	28	18	46	..	..	..	11	7	18
Virginia	209	132	341	209	132	341	..	..	..	..	..	..
Washington	....	....	....	....	....	....	..	..	..	..	..	..
West Virginia	129	70	199	129	70	199	..	..	..	..	..	..
Wisconsin	96	67	163	1	....	1	91	66	157	4	1	5
Wyoming	11	7	18	11	7	18	..	..	..	..	..	..

Table IV—Inebriates in institutions in the several states of the Union, January 1, 1918

State	Total			Public						Private		
				State institutions			Other institutions					
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
United States......	2,658	907	3,565	1,004	245	1,249	1,157	434	1,591	497	228	725
Alabama..........	....	....	....	....	....	....	....	..	....	..	..	..
Arizona..........	10	4	14	10	4	14	....	..	....	..	..	..
Arkansas..........	6	3	9	6	3	9	....	..	....	..	..	..
California..........	246	72	318	217	61	278	22	9	31	7	2	9
Colorado..........	2	1	3	....	....	....	....	..	....	2	1	3
Connecticut..........	107	12	119	82	....	82	....	..	....	25	12	37
Delaware..........	6	....	6	6	....	6	....	..	....	..	..	..
Dist. of Columbia..	3	3	6	....	....	....	3	3	6	..	..	..
Florida..........	14	6	20	14	6	20	....	..	....	..	..	..
Georgia..........	20	18	38	13	12	25	....	..	....	7	6	13
Idaho..........	9	....	9	9	....	9	....	..	....	..	..	..
Illinois..........	96	28	124	29	2	31	....	..	....	67	26	93
Indiana..........	25	9	34	20	3	23	....	..	....	5	6	11
Iowa..........	136	22	158	81	10	91	54	11	65	1	1	2
Kansas..........	....	2	2	....	1	1	....	..	....	..	1	1
Kentucky..........	9	3	12	1	2	3	....	..	....	8	1	9
Louisiana..........	41	28	69	30	20	50	3	..	3	8	8	16
Maine..........	19	1	20	19	1	20	....	..	....	..	..	..
Maryland..........	569	216	785	52	11	63	500	200	700	17	5	22
Massachusetts.....	143	68	211	114	18	132	....	..	....	29	50	79
Michigan..........	57	19	76	35	10	45	1	..	1	21	9	30
Minnesota..........	21	6	27	19	6	25	....	..	....	2	..	2
Mississippi..........	6	6	12	6	6	12	....	..	....	..	..	..
Missouri..........	53	16	69	32	5	37	18	11	29	3	..	3
Montana..........	....	....	....	....	....	....	....	..	....	..	..	..
Nebraska..........	7	1	8	7	1	8	....	..	....	..	..	..
Nevada..........	18	9	27	18	9	27	....	..	....	..	..	..
New Hampshire ...	5	2	7	5	2	7	....	..	....	..	..	..
New Jersey	186	61	247	....	....	....	115	42	157	71	19	90
New Mexico.......	29	3	32	29	3	32	....	..	....	..	..	..
New York	160	44	204	....	....	....	112	24	136	48	20	68
North Carolina....	19	4	23	....	....	....	....	..	....	19	4	23
North Dakota.....	....	....	....	....	....	....	....	..	....	..	..	..
Ohio..........	23	7	30	....	....	....	5	..	5	18	7	25
Oklahoma..........	5	6	11	1	6	7	....	..	....	4	..	4
Oregon..........	8	1	9	2	....	2	....	..	....	6	1	7
Pennsylvania......	329	143	472	20	5	25	234	116	350	75	22	97
Rhode Island......	....	....	....	....	....	....	....	..	....	..	..	..
South Carolina	....	....	....	....	....	....	....	..	....	..	..	..
South Dakota	....	....	....	....	....	....	....	..	....	..	..	..
Tennessee..........	51	30	81	12	6	18	17	10	27	22	14	36
Texas..........	31	5	36	14	....	14	....	..	....	17	5	22
Utah..........	....	....	....	....	....	....	....	..	....	..	..	..
Vermont..........	16	5	21	10	3	13	....	..	....	6	2	8
Virginia..........	....	2	2	....	....	....	....	..	....	..	2	2
Washington..........	....	....	....	....	....	....	....	..	....	..	..	..
West Virginia	30	23	53	30	23	53	....	..	....	..	..	..
Wisconsin..........	140	18	158	58	6	64	73	8	81	9	4	13
Wyoming..........	3	....	3	3	....	3	....	..	....	..	..	..

Table V—Increase in insane in institutions in the several states of the Union, from January 1, 1910 to January 1, 1918, compared with increase of general population

State	Insane								Per cent increase of general population
	January 1, 1910			January 1, 1918			Increase		
	Males	Females	Total	Males	Females	Total	Number	Per cent	
United States	98,695	89,096	187,791	125,919	113,901	239,820	52,029	27.7	13.6
Alabama	981	1,058	2,039	1,151	1,269	2,420	381	18.7	11.3
Arizona	265	72	337	341	126	467	130	38.6	31.1
Arkansas	529	563	1,092	779	809	1,588	496	45.4	13.0
California	4,115	2,537	6,652	5,826	4,095	9,921	3,269	49.1	29.3
Colorado	687	512	1,199	1,016	769	1,785	586	48.9	25.3
Connecticut	1,680	1,899	3,579	2,026	2,269	4,295	716	20.0	14.4
Delaware	237	204	441	278	230	508	67	15.2	6.8
Dist. of Columbia	2,170	720	2,890	2,524	868	3,392	502	17.4	12.2
Florida	446	403	849	685	578	1,263	414	48.8	23.2
Georgia	1,531	1,601	3,132	1,871	2,057	3,928	796	25.4	11.8
Idaho	256	132	388	309	194	503	115	29.6	39.3
Illinois	6,846	5,993	12,839	9,426	8,089	17,515	4,676	36.4	11.3
Indiana	2,235	2,292	4,527	2,912	2,792	5,704	1,177	26.0	5.3
Iowa	2,896	2,481	5,377	4,013	3,323	7,336	1,959	36.4	....
Kansas	1,694	1,218	2,912	1,691	1,381	3,072	160	5.5	10.2
Kentucky	1,968	1,570	3,538	2,453	2,027	4,480	942	26.6	4.9
Louisiana	1,070	1,088	2,158	1,266	1,294	2,560	402	18.6	12.9
Maine	693	565	1,258	781	771	1,552	294	23.4	5.0
Maryland	1,569	1,651	3,220	1,882	2,036	3,918	698	21.7	6.5
Massachusetts	5,633	5,968	11,601	7,235	7,373	14,608	3,007	25.9	13.0
Michigan	3,679	3,020	6,699	4,154	3,521	7,675	976	14.6	10.8
Minnesota	2,755	1,989	4,744	3,597	2,610	6,207	1,463	30.8	12.2
Mississippi	933	1,045	1,978	756	855	1,611	*367	*18.6	10.7
Missouri	3,231	2,937	6,168	4,370	3,331	7,701	1,533	24.9	4.4
Montana	531	166	697	865	347	1,212	515	73.9	27.5
Nebraska	1,141	849	1,990	1,424	1,126	2,550	560	28.1	8.2
Nevada	165	65	230	159	61	220	*10	*4.3	37.7
New Hampshire	463	446	909	551	594	1,145	236	26.0	3.4
New Jersey	2,913	3,129	6,042	3,570	3,959	7,529	1,487	24.6	20.1
New Mexico	128	91	219	137	127	264	45	20.5	31.5
New York	14,955	16,325	31,280	18,796	20,812	39,608	8,328	26.6	15.8
North Carolina	1,032	1,490	2,522	1,314	1,900	3,214	692	27.4	11.1
North Dakota	407	221	628	743	432	1,175	547	87.1	34.9
Ohio	5,615	4,979	10,594	6,665	5,879	12,544	1,950	18.4	10.0
Oklahoma	651	459	1,110	1,103	854	1,957	847	76.3	40.8
Oregon	1,088	477	1,565	1,507	766	2,273	708	45.2	30.1
Pennsylvania	7,919	7,139	15,058	10,176	8,889	19,065	4,007	26.6	13.9
Rhode Island	650	593	1,243	820	741	1,561	318	25.6	16.4
South Carolina	708	833	1,541	925	995	1,920	379	24.6	9.0
South Dakota	535	329	864	677	477	1,154	290	33.6	24.4
Tennessee	1,057	1,147	2,204	1,245	1,434	2,679	475	21.6	5.9
Texas	2,087	1,966	4,053	2,851	2,937	5,788	1,735	42.8	17.0
Utah	171	171	342	314	269	583	241	70.5	20.2
Vermont	528	462	990	503	475	978	*12	*1.2	2.7
Virginia	1,779	1,856	3,635	2,408	2,370	4,778	1,143	31.4	7.9
Washington	1,325	662	1,987	2,064	1,218	3,282	1,295	65.2	42.6
West Virginia	900	822	1,722	1,288	1,063	2,351	629	36.5	16.8
Wisconsin	3,743	2,844	6,587	4,316	3,439	7,755	1,168	17.7	8.9
Wyoming	105	57	162	156	70	226	64	39.5	28.6

* Decrease.

Table VI—Insane in institutions in the United States by divisions and states on January 1 of 1910, 1917 and 1918

State	Number			Rate per 100,000 of general population		
	1910	1917	1918	1910	1917	1918
United States	187,791	232,873	239,820	204.2	226.5	229.6
New England	19,580	23,542	24,139	298.8	326.7	330.6
Maine	1,258	1,493	1,552	169.5	192.7	199.0
New Hampshire	909	1,098	1,145	211.1	247.6	257.1
Vermont	990	1,110	978	278.1	304.7	267.5
Massachusetts	11,601	14,096	14,608	344.6	376.1	384.0
Rhode Island	1,243	1,565	1,561	229.1	252.4	247.1
Connecticut	3,579	4,180	4,295	321.1	333.1	336.6
Middle Atlantic	52,380	65,145	66,202	271.2	296.9	296.5
New York	31,280	38,117	39,608	343.2	367.7	375.3
New Jersey	6,042	7,592	7,529	238.1	254.7	247.1
Pennsylvania	15,058	19,436	19,065	196.4	226.2	218.4
East North Central	41,246	49,686	51,193	226.0	251.1	255.7
Ohio	10,594	12,307	12,544	222.2	237.5	239.3
Indiana	4,527	5,769	5,704	167.6	204.1	200.5
Illinois	12,839	16,354	17,515	227.7	264.0	279.1
Michigan	6,699	7,377	7,675	238.4	239.9	246.5
Wisconsin	6,587	7,879	7,755	282.2	313.4	305.2
West North Central	22,683	27,516	29,195	194.9	219.8	230.8
Minnesota	4,744	5,857	6,207	228.5	255.1	266.5
Iowa	5,377	6,367	7,336	241.7	286.2	329.7
Missouri	6,168	7,512	7,701	187.3	219.6	223.9
North Dakota	628	1,079	1,175	108.8	143.4	151.0
South Dakota	864	1,059	1,154	148.0	149.6	158.9
Nebraska	1,990	2,485	2,550	166.9	194.5	197.6
Kansas	2,912	3,157	3,072	172.2	171.5	164.9
South Atlantic	19,952	24,758	25,272	163.6	185.0	186.3
Delaware	441	484	508	218.0	225.9	235.1
Maryland	3,220	4,035	3,918	248.6	294.9	284.1
District of Columbia	2,890	3,082	3,392	872.9	840.6	912.0
Virginia	3,635	4,398	4,778	176.3	199.7	214.9
West Virginia	1,722	2,127	2,351	141.0	152.0	164.9
North Carolina	2,522	3,446	*3,214	114.3	142.5	*131.2
South Carolina	1,541	1,642	1,920	101.7	100.5	116.2
Georgia	3,132	4,062	3,928	120.0	141.2	134.7
Florida	849	1,482	1,263	112.8	163.8	136.2
East South Central	9,759	11,231	11,190	116.0	124.9	123.2
Kentucky	3,538	4,348	4,480	154.5	182.2	186.6
Tennessee	2,204	2,518	2,679	100.9	109.7	115.8
Alabama	2,039	2,341	2,420	95.4	99.7	101.7
Mississippi	1,978	2,024	1,611	110.1	103.0	81.0
West South Central	8,413	10,789	11,893	95.8	104.6	112.8
Arkansas	1,092	1,628	1,588	69.4	92.9	89.2
Louisiana	2,158	2,552	2,560	130.3	138.5	136.8
Oklahoma	1,110	1,576	1,957	67.0	70.2	83.9
Texas	4,053	5,033	5,788	104.0	112.5	127.0

* Not including Hospital for the Dangerous Insane.

Table VI—Insane in institutions in the United States by divisions and states on January 1 of 1910, 1917 and 1918—Continued

State	Number			Rate per 100,000 of general population		
	1910	1917	1918	1910	1917	1918
Mountain	3,574	4,887	5,260	135.7	148.8	155.5
Montana	697	1,083	1,212	185.3	232.3	252.7
Idaho	388	540	503	119.2	123.6	110.9
Wyoming	162	220	226	111.0	120.7	120.4
Colorado	1,199	1,613	1,785	150.1	165.4	178.2
New Mexico	219	302	264	66.9	72.4	61.3
Arizona	337	411	467	164.9	158.3	174.3
Utah	342	474	583	91.6	108.0	129.9
Nevada	230	244	220	280.9	224.4	195.1
Pacific	10,204	15,319	15,476	243.4	283.8	277.4
Washington	1,987	3,312	3,282	174.0	211.5	201.5
Oregon	1,565	2,309	2,273	232.6	272.0	259.7
California	6,652	9,698	9,921	279.8	325.0	322.7

Table VII—Comparison between feebleminded in institutions in the several states in the Union on January 1 of 1910, 1917 and 1918

State	Number			Increase	
	1910	1917	1918	1910 to 1918	1917 to 1918
United States	20,731	36,814	39,381	18,650	2,567
Alabama	....	....	....	....	....
Arizona	....	50	3	3	†47
Arkansas	....	165	238	238	73
California	854	1,294	1,461	607	167
Colorado	64	224	97	33	†127
Connecticut	294	438	360	66	†78
Delaware	....	30	22	22	†8
District of Columbia	....	143	11	11	†132
Florida	....	....	148	148	148
Georgia	....	4	7	7	3
Idaho	....	61	82	82	21
Illinois	1,265	2,305	2,332	1,067	27
Indiana	1,135	1,523	1,508	373	†15
Iowa	1,189	1,772	1,828	639	56
Kansas	420	1,053	654	234	†399
Kentucky	283	504	497	214	†7
Louisiana	....	128	146	146	18
Maine	62	376	403	341	27
Maryland	310	708	1,113	803	405
Massachusetts	1,464	3,213	3,124	1,660	†89
Michigan	986	1,632	1,834	848	202
Minnesota	1,194	1,372	1,458	264	86
Mississippi	....	154	380	380	226
Missouri	512	633	1,006	494	373
Montana	51	83	101	50	18
Nebraska	446	551	571	125	20
Nevada	....	....	2	2	2
New Hampshire	144	374	355	211	†19
New Jersey	640	1,298	1,475	835	177
New Mexico	....	5	17	17	12
New York	3,421	5,525	5,810	2,389	285
North Carolina	....	205	193	193	†12
North Dakota	145	276	209	64	†67
Ohio	1,526	2,199	2,219	693	20
Oklahoma	....	302	528	528	226
Oregon	....	372	356	356	†16
Pennsylvania	2,705	4,361	4,687	1,982	326
Rhode Island	48	244	309	261	65
South Carolina	....	139	144	144	5
South Dakota	*....	317	345	....	28
Tennessee	47	27	87	40	60
Texas	19	77	92	73	15
Utah	45	66	44	†1	†22
Vermont	....	69	191	191	122
Virginia	60	353	307	247	†46
Washington	159	550	614	455	64
West Virginia	214	98	272	58	174
Wisconsin	1,029	1,477	1,656	627	179
Wyoming	....	64	85	85	21

* No report. † Decrease.

Table VIII—Insane patients in state hospitals and on parole from state hospitals in the several states on January 1, 1918

State	On books of hospitals			On parole			Per cent of total on parole
	Males	Females	Total	Males	Females	Total	
United States	109,994	97,711	207,705	8,190	7,673	15,863	7.6
Alabama	1,151	1,269	2,420	171	149	320	13.2
Arizona	341	126	467	†36	†12	48	10.3
Arkansas	779	809	1,588	338	355	693	43.6
California	5,752	4,004	9,756	309	351	660	6.8
Colorado	956	710	1,666	35	23	58	3.5
Connecticut	1,872	1,956	3,828	185	93	278	7.3
Delaware	278	230	508	12	14	26	5.1
District of Columbia	2,482	852	3,334	63	28	91	2.7
Florida	685	578	1,263	....	....	....	....
Georgia	1,847	2,030	3,877	44	57	101	2.6
Idaho	309	194	503	34	18	52	10.3
Illinois	9,327	7,951	17,278	324	329	653	3.8
Indiana	2,809	2,701	5,510	310	191	501	9.1
Iowa	2,648	2,009	4,657	293	315	608	13.1
Kansas	1,673	1,362	3,035	190	170	360	11.9
Kentucky	2,444	2,011	4,455	91	77	168	3.8
Louisiana	1,198	1,121	2,319	*....	*....	*....	*....
Maine	773	764	1,537	74	74	148	9.6
Maryland	1,351	1,283	2,634	*....	*....	*....	*....
Massachusetts	7,077	7,099	14,176	897	874	1,771	12.5
Michigan	3,642	2,870	6,512	....	....	....	....
Minnesota	3,579	2,580	6,159	358	305	663	10.8
Mississippi	756	855	1,611	55	38	93	5.8
Missouri	2,651	2,218	4,869	129	143	272	5.6
Montana	865	347	1,212	94	52	146	12.0
Nebraska	1,408	1,098	2,506	97	88	185	7.4
Nevada	159	61	220	6	7	13	5.9
New Hampshire	551	594	1,145	....	....	....	....
New Jersey	2,289	2,202	4,491	115	76	191	4.3
New Mexico	137	127	264	16	6	22	8.3
New York	18,358	19,953	38,311	1,033	1,223	2,256	5.9
North Carolina	1,294	1,868	3,162	151	215	366	11.6
North Dakota	743	432	1,175	76	61	137	11.7
Ohio	6,561	5,722	12,283	579	471	1,050	8.5
Oklahoma	1,088	842	1,930	*....	*....	*....	*....
Oregon	1,320	735	2,055	53	81	134	6.5
Pennsylvania	5,291	4,232	9,523	330	265	595	6.2
Rhode Island	758	665	1,423	147	141	288	20.2
South Carolina	925	995	1,920	81	65	146	7.6
South Dakota	677	477	1,154	21	14	35	3.0
Tennessee	1,021	1,164	2,185	....	....	....	....
Texas	2,783	2,852	5,635	300	409	709	12.6
Utah	314	269	583	....	....	....	....
Vermont	294	290	584	4	1	5	0.9
Virginia	2,396	2,366	4,762	428	363	791	16.6
Washington	2,059	1,211	3,270	191	145	336	10.3
West Virginia	1,288	1,063	2,351	135	113	248	10.5
Wisconsin	879	494	1,373	376	256	632	46.0
Wyoming	156	70	226	9	5	14	6.2

* Data not received.   † Estimated.

Table IX—Admissions of insane patients to state hospitals in 1910 and in 1917

State	Admissions						Number per 100,000 of general population	
	In 1910			In 1917				
	Males	Females	Total	Males	Females	Total	In 1910	In 1917
United States	26,191	19,603	45,794	36,111	26,787	62,898	49.8	60.7
Alabama	444	387	831	518	469	987	38.9	41.8
Arizona	104	31	135	*128	*44	172	66.1	65.2
Arkansas	152	103	255	542	396	938	16.2	53.1
California	1,161	632	1,793	1,589	1,006	2,595	75.4	85.7
Colorado	233	120	353	298	149	447	44.2	45.2
Connecticut	379	307	686	576	448	1,024	61.5	80.9
Delaware	78	49	127	77	42	119	62.8	55.3
District of Columbia	426	171	597	668	230	898	180.3	243.2
Florida	196	129	325	348	258	606	43.2	66.1
Georgia	542	453	995	595	592	1,187	38.1	41.0
Idaho	155	48	203	149	66	215	62.3	48.3
Illinois	1,499	1,148	2,647	4,379	2,431	6,810	46.9	109.2
Indiana	616	525	1,141	625	507	1,132	42.2	39.9
Iowa	591	428	1,019	561	416	977	45.8	43.9
Kansas	367	252	619	412	274	686	36.6	37.0
Kentucky	677	441	1,118	736	539	1,275	48.8	53.3
Louisiana	178	182	360	*265	*178	*443	21.7	23.9
Maine	248	261	509	248	210	458	68.6	58.9
Maryland	189	157	346	394	320	714	26.7	52.0
Massachusetts	2,070	1,871	3,941	3,004	2,722	5,726	117.1	151.6
Michigan	870	654	1,524	1,077	788	1,865	54.2	60.3
Minnesota	858	547	1,405	1,265	654	1,919	67.7	83.0
Mississippi	378	317	695	510	407	917	38.7	46.4
Missouri	675	489	1,164	748	539	1,287	35.3	37.5
Montana	212	66	278	436	154	590	73.9	124.8
Nebraska	243	168	411	319	248	567	34.5	44.2
Nevada	45	11	56	55	20	75	68.4	67.7
New Hampshire	157	143	300	176	152	328	69.7	73.8
New Jersey	528	429	957	734	583	1,317	37.7	43.7
New Mexico	60	24	84	111	68	179	25.7	42.3
New York	4,186	3,646	7,832	5,291	4,882	10,173	85.9	97.3
North Carolina†	390	433	823	363	416	779	37.3	32.0
North Dakota	142	82	224	171	82	253	38.8	33.1
Ohio	1,676	1,171	2,847	2,200	1,401	3,601	59.7	69.1
Oklahoma	37	19	56	568	395	963	3.4	42.1
Oregon	447	143	590	287	158	445	87.8	51.6
Pennsylvania	880	654	1,534	1,037	753	1,790	20.0	20.7
Rhode Island	211	167	378	261	219	480	69.7	76.7
South Carolina	338	308	646	526	505	1,031	42.6	62.7
South Dakota	126	73	199	143	95	238	34.1	33.2
Tennessee	344	277	621	428	430	858	28.4	37.2
Texas	689	576	1,265	597	592	1,189	32.5	26.3
Utah	66	37	103	113	87	200	27.6	45.1
Vermont	83	59	142	106	70	176	39.9	48.2
Virginia	691	543	1,234	879	775	1,654	59.9	74.7
Washington	609	275	884	606	316	922	77.4	57.7
West Virginia	266	229	495	257	226	483	40.5	34.2
Wisconsin	703	417	1,120	691	463	1,154	48.0	45.7
Wyoming	30	12	42	44	12	56	28.8	30.3

* Estimated.

† Not including Hospital for the Dangerous Insane.

Table X—Deaths of insane patients in state hospitals in 1910 and in 1917

State	Deaths						Death rate per 1,000 of insane in state hospitals	
	In 1910			In 1917				
	Males	Females	Total	Males	Females	Total	In 1910	In 1917
United States	9,117	6,359	15,476	13,792	9,717	23,509	97	116
Alabama	157	170	327	198	231	429	160	183
Arizona	36	8	44	*57	*13	70	131	170
Arkansas	68	50	118	247	143	390	108	240
California	397	191	588	745	354	1,099	114	115
Colorado	50	16	66	139	45	184	75	123
Connecticut	144	114	258	264	239	503	84	131
Delaware	23	25	48	34	19	53	109	110
District of Columbia	206	73	279	326	109	435	97	142
Florida	76	42	118	173	108	281	139	190
Georgia	236	210	446	298	276	574	145	143
Idaho	23	10	33	49	15	64	85	119
Illinois	567	410	977	1,391	763	2,154	92	134
Indiana	256	136	392	288	208	496	91	90
Iowa	248	147	395	198	162	360	96	75
Kansas	148	66	214	220	125	345	85	111
Kentucky	250	170	420	315	185	500	120	116
Louisiana	74	72	146	*83	*51	*134	76	58
Maine	83	83	166	139	82	221	132	149
Maryland	68	51	119	*178	*126	*304	78	102
Massachusetts	619	504	1,123	843	815	1,658	99	121
Michigan	372	221	593	455	290	745	101	114
Minnesota	249	134	383	314	199	513	81	88
Mississippi	111	126	237	169	97	266	120	131
Missouri	262	195	457	317	207	524	108	109
Montana	60	12	72	97	46	143	103	132
Nebraska	116	58	174	139	101	240	87	98
Nevada	13	8	21	25	10	35	91	143
New Hampshire	78	63	141	79	51	130	161	118
New Jersey	173	135	308	242	192	434	91	100
New Mexico	32	7	39	48	22	70	178	232
New York	1,445	1,190	2,635	2,113	1,849	3,962	87	108
North Carolina	112	98	210	†161	†166	†327	84	†97
North Dakota	39	14	53	57	32	89	84	82
Ohio	681	413	1,094	884	535	1,419	105	117
Oklahoma	19	11	30	166	124	290	64	185
Oregon	119	34	153	142	71	213	98	101
Pennsylvania	315	253	568	509	329	838	75	88
Rhode Island	64	48	112	151	113	264	102	186
South Carolina	150	147	297	193	192	385	193	234
South Dakota	50	24	74	73	23	96	92	96
Tennessee	88	84	172	135	134	269	94	121
Texas	195	143	338	224	200	424	85	87
Utah	19	18	37	24	22	46	108	97
Vermont	31	21	52	43	32	75	91	112
Virginia	239	182	421	358	321	679	116	154
Washington	168	52	220	217	97	314	60	111
West Virginia	98	76	174	163	125	288	101	135
Wisconsin	84	39	123	96	62	158	98	118
Wyoming	6	5	11	13	6	19	68	86

* Estimated. † Not including Hospital for the Dangerous Insane.

Table XI—Cost of maintenance of patients in state hospitals, and average daily patient population for the fiscal year of 1917

State	Average daily patient population	Cost of maintenance	
		Total	Per capita of average daily population
United States	211,916	$43,926,888.88	$207.28
Alabama	2,281	420,511.97	184.35
Arizona	493	92,406.17	187.44
Arkansas	2,011	348,953.60	173.52
California	10,095	2,105,368.71	208.56
Colorado	1,596	344,391.56	215.78
Connecticut	3,859	918,902.18	238.12
Delaware	504	105,862.26	210.04
District of Columbia	3,209	779,000.00	242.75
Florida	1,529	323,495.62	211.57
Georgia	4,056	795,817.94	196.21
Idaho	631	105,824.00	167.71
Illinois†	17,623	3,314,322.86	188.07
Indiana	5,542	1,228,458.35	221.66
Iowa	4,666	896,056.68	192.04
Kansas†	3,032	521,041.81	171.85
Kentucky	4,371	685,646.47	156.86
Louisiana*	2,543	390,497.47	153.56
Maine	1,691	519,084.15	306.97
Maryland	3,027	666,204.40	220.09
Massachusetts†	15,102	4,438,401.33	293.89
Michigan	6,958	1,650,713.48	237.24
Minnesota	6,077	1,047,353.58	172.35
Mississippi	2,264	359,484.97	158.78
Missouri	4,993	1,037,721.79	207.84
Montana	1,200	295,000.00	245.83
Nebraska	2,502	519,018.26	207.44
Nevada	249	58,744.55	235.92
New Hampshire	1,206	318,533.41	264.12
New Jersey	4,407	1,109,208.01	251.69
New Mexico	318	68,089.45	214.12
New York	37,164	7,872,857.93	‡211.84
North Carolina†	3,460	622,312.77	179.86
North Dakota	1,152	214,219.40	185.95
Ohio	12,100	1,954,811.51	161.55
Oklahoma	2,240	452,084.31	201.82
Oregon	2,103	344,580.53	163.85
Pennsylvania	9,668	2,345,289.91	242.58
Rhode Island	1,411	286,309.36	202.91
South Carolina	2,070	410,271.79	198.20
South Dakota	1,059	246,000.00	232.29
Tennessee	2,208	365,634.56	165.60
Texas	5,613	879,142.40	156.63
Utah	600	107,310.00	178.85
Vermont	749	180,198.00	240.58
Virginia	4,988	677,853.90	135.90
Washington	3,252	630,580.62	193.91
West Virginia	2,451	425,574.65	173.63
Wisconsin	1,371	406,263.00	296.33
Wyoming	222	41,479.12	186.84

* Estimated.
† Not including hospital for criminal insane.
‡ If paroles excluded, per capita cost is $220.89.

NOTES AND COMMENTS

California

The new state school for the feebleminded, the second in the state, which was authorized by the 1918 legislature of California, will be located at Pomona. The site selected contains 1,300 acres and the cost of the school when completed will be $2,000,000. The home will care for 2,000 pupils.

Colorado

A bill has recently been presented before the general assembly to establish an institution under the name of the Psychopathic Hospital and Laboratory of the University of Colorado. It would be located at Denver and would be under the full control and supervision of the University of Colorado. The bill would authorize voluntary admission to this hospital, provided the person making application paid for treatment in advance.

An appropriation of $175,000 is included in the bill, for the purchase of land and the construction of buildings. The bill would also provide a sum for the maintenance of the hospital and laboratory.

The superintendent would be a physician with at least ten years' practice and with a minimum of five years' experience as a neuro-pathologist.

Connecticut

A bill is to be presented to the 1919 legislature providing for state care of the insane. At present the cost of maintenance of any patient in a state hospital in Connecticut is borne in part by the state and in part by the town in which he had legal residence.

Georgia

A resolution was passed by the 1918 legislature requesting the Governor to appoint a committee to make an investigation as to the numbers and conditions of the feebleminded persons in the state who were then or were likely to become public charges. The National Committee for Mental Hygiene was invited to assist in this investigation, and has sent Dr. V. V. Anderson, formerly Medical Director, Municipal Court, Boston, and now in charge of the special work in mental deficiency of the National Committee to conduct this survey for the Georgia Commission on Provision for the Feebleminded. Already the investigation is well under way, and earnest cooperation is being shown by the Governor, other state officials and the people of Georgia.

Illinois

Among other plans in contemplation in Illinois are the establishment of a Psychopathic Hospital, a Bureau of Juvenile Research and additional provision for the feebleminded.

Kentucky

The Colony for the Feebleminded, established under provisions of an act of the last legislature, will be located two miles from Frankfort.

In accordance with Chapter 24, Laws of 1918, a State Board of Control has been created supplanting the Board of Control and the Board of Penitentiary Commissioners of the State of Kentucky. All the duties and powers of the two former boards are now vested in the newly established one. It is composed of five members appointed by the governor with the consent of the senate.

Massachusetts

A number of bills of interest have recently been presented before the Massachusetts legislature. One of these would establish a farm colony for mental defectives. Another bill forbids the issuance of a marriage license to any feebleminded person, whether idiot, imbecile or moron. This bill also declares that a marriage between a normal person and a feebleminded one shall not be held to be legal. The bill further provides that any person coming in contact with an individual he believes to be feebleminded shall report his name and address, with facts concerning him, to the secretary of state or other designated person. Failure to report such a case would render a person liable to fine. Under this bill, an applicant for a marriage license must furnish satisfactory evidence that his mental and chronological age correspond. This bill further states: "All feebleminded persons in the commonwealth shall be regularly committed, voluntarily or involuntarily, to institutions for the feebleminded."

Another bill recently introduced authorizes the State Department of Health, the Board of Education and the Commission on Mental Diseases to make a joint investigation of the medical inspection of the schools of the commonwealth, and to report the results of their investigation to the next general court together with draft of bills designed to coordinate and improve the system.

Another bill worthy of note reads as follows: "If a person is found by two physicians qualified as provided in section thirty-two of the acts of nineteen hundred and nine, to be in such mental condition that his commitment to a hospital for the insane is necessary for his proper care or observation, he may be committed by any of the judges mentioned in section twenty-nine to a state hospital for the insane or to the McLean Hospital for a period of thirty-five days pending the determination of his insanity.

"Within thirty days after such commitment the superintendent of the hospital to which the person has been committed shall discharge him if he is not insane and notify the judge who committed him, or if he is insane he shall report the patient's mental condition to the magistrate who committed him, with the recommendation that he shall be committed as an insane person or discharged to the care of his guardian, relatives or friends if he is harmless and can be properly cared for by them.

"Within said thirty-five days, the committing magistrate may authorize such discharge or he may commit the patient to the hospital as an insane person if in his opinion such commitment is necessary. If in the opinion of the judge additional medical testimony as to the mental condition of the alleged insane person is desirable, he may appoint a physician to examine and report thereon."

The following bill also is worthy of mention: "If a person, held in custody in jail, under complaint or indictment for any crime pending in the superior court holden for criminal business, in any county, is at the time appointed for trial or sentence or any time prior thereto, found by said court to be feebleminded, said court may commit him to a school for feebleminded, in said commonwealth, under such limitations as it may order, and as provided for the examination and commitment of insane prisoners by chapter five hundred and four, section one hundred and three, of the acts of nineteen hundred and nine, and amendments thereto."

Another bill would authorize the Massachusetts Commission on Mental Diseases, if it has reason to believe that there is a neglected, dangerous or uncontrolled feebleminded person in the community, to cause an investigation to be made by an agent of the Commission, and to have the alleged feebleminded person examined by a physician to determine whether he requires commitment. Application for commitment would be made to the judge of probate in the county in which the person is found. The judge might commit him to a state school for the feebleminded, to an institution for defective delinquents or to the custody of the Commission. This bill further empowers the Commission to establish and maintain free clinics for feebleminded to be in charge of physicians of the state schools for the feebleminded or other physicians designated by the Commission. The Commission would also be authorized to make a survey of the feebleminded and to make a report with recommendations to the general court not later than January 15, 1921.

The establishment of a hospital for the treatment of acute and curable voluntary mental patients would be authorized by the terms of another bill recently presented.

New York

A bill has recently been introduced in the legislature to codify the state laws relative to the feebleminded and to provide a uniform statewide commitment law. This bill provides for the continuance of the State Commission for the Feebleminded, created last year to consist of three members—a qualified physician, the Fiscal Supervisor of State Charities and the Secretary of the State Board of Charities. All private institutions caring for three or more mentally defective persons would require a license and be under the supervision of the Commission. The bill advocates the establishment of colonies in connection with the state schools for the feebleminded, also the changing of the names of these schools as follows: The Institution for Feebleminded Children, at Syracuse, to be called the Syracuse State Training School for Backward Children; the State Custodial Asylum for Feebleminded Women, at Newark, to be known as the Newark State Training School; the Rome State Custodial Asylum, as the Rome State Training School; and Letchworth Village, as the Letchworth Village State Training School.

In addition to the regular procedure providing for commitment, emergency care for a period not to exceed twenty days, and also voluntary admissions would be authorized. Provisions for the discharge and parole of the feebleminded are also included in this bill. The parole provision reads as follows: "An inmate of any of the state training schools may be permitted by the superintendent and with the consent of the board of managers to leave the institution on parole and remain in the custody of a parent or other relative or guardian. At any time during the first year of such parole, upon evidence satisfactory to the superintendent, to the board of managers and to the state commission for the feebleminded, such inmate may be recalled to the institution without a legal commitment. After the expiration of one year parole, however, further legal commitment shall be required for readmission, unless such inmate is readmitted under the provisions for voluntary commitment or commitment by desire of a parent or guardian. The above provision for parole shall not include any persons who are under sentence by any court. Every parent or relative or guardian to whom such inmate shall be paroled shall report the physical and moral and mental condition of the inmate to the superintendent either in person or by writing as often and as fully as he may require, and in case of failure to so report on request the inmate may be recalled to the institution. At any time during the year of parole the inmate shall be accessible to the parole agent of the institution. The institution paroling a patient shall not be liable for his expenses while on parole. Such liability shall devolve upon the relative, committee or persons to whose care the patient is paroled or the proper poor official of the town or county in which he may have found domicile."

The special committee appointed in June, 1918, by the State Commission of Prisons, to investigate the matter of mental disease and delinquency has recently filed its report. The committee, with the cooperation of The National Committee for Mental Hygiene and the assistance of Dr. V. V. Anderson, made an examination of the penal and correctional institutions in the state and of clinical work in connection with courts, collecting data with reference to mental examinations of delinquents in New York and other states. The report contains a number of statistical tables showing percentages of inmates of prisons, reformatories, penitentiaries and industrial training schools, who are feebleminded or exhibit nervous or mental abnormalities. Tables are also presented to show percentages of inmates regarded as segregable in certain prisons and reformatories.

The committee believes that the crux of the criminal problem is found in the recidivist—the chronic repeater. Sixty per cent of the population of the various penal and correctional institutions in New York state have served previous terms. The most important factor associated with chronic criminalism is the abnormal mental condition of the criminal himself. At least 50 per cent of the inmates of prisons and reformatories in New York state exhibit mental abnormalities; from 27 to 30 per cent of such inmates are feebleminded. In the light of such facts, the report states, it is futile to go on blindly administering the law without endeavoring to solve the problem presented by the individual.

The following recommendations are made:

1. "That all males convicted of felony and not released under suspension of imposition or execution of sentence pass through the proposed clearing house at Sing Sing Prison, and thence be distributed to each of the state prisons and the New York State Reformatory at Elmira in the light of the needs of each case.

2. "That all sentenced female felons and those convicted of offenses of a lesser degree than felony selected by the court, pass through a clearing house to be established by the state at the New York State Reformatory for Women at Bedford Hills, and from this clearing house, after a period of study and reconstruction, be distributed to other state institutions for women in the light of the needs of each case.

3. "The prompt establishment of the proposed clearing houses on Blackwell's Island to function for the Department of Correction of New York City in the same way as the Sing Sing and Bedford Hills clearing houses function for the state institutions, converting the penitentiary into a clearing house for men and the workhouse into a clearing house for women.

4. "The establishment of a state institution for the care and treatment of male defective delinquents, providing for their commitment, release and transfer. The Eastern New York Reformatory at Napanoch is suggested.

5. "The establishment of a state institution for the care and treatment of female defective delinquents, providing for their commitment, release and transfer. The New York State Reformatory for Women at Bedford Hills is suggested.

6. "The establishment of an institution in connection with the Department of Correction of the City of New York for the care and treatment of male defective delinquents.

7. "The establishment of an institution in connection with the Department of Correction of the City of New York for the care and treatment of female defective delinquents.

8. "That all children brought before the court, charged with delinquency or improper guardianship, be examined mentally, the examinations to be made either in a clinic attached to the court, or in a central clinic to be provided, and those found feebleminded to be committed to proper institutions if in need of institutional care.

9. "That all adults convicted of offenses less than felony and all adults convicted of felony and released under suspension of imposition or execution of sentence, be examined mentally in the discretion of the judge at a clinic attached to the court or at a central clinic.

10. "The establishment of mental clinics throughout the state as planned by the State Commission for the Feebleminded, and the establishment of a psychopathic hospital in New York City as proposed by the State Hospital Development Commission.

11. "The creation of a state board to supervise and direct the activities of these mental clinics, thereby securing proper standardization in the way of methods used and results obtained.

12. "That the legislature be requested to enact such legislation as will put these recommendations into effect."

Pennsylvania

Selinsgrove has been chosen as the site of the hospital for mental disease authorized by the 1917 legislature.

A bill to regulate marriage has recently been presented to the legislature. It would deny the issuance of a license to insane persons, habitual drunkards, habitual criminals, epileptics, persons of "unsound mind," and to any one not free from venereal disease.

An amendment to the school code to encourage the formation of special classes in the public schools, for the observation and training of backward or mentally exceptional children, is being considered in Pennsylvania. Adequate appropriations are being urged for the completion of the two new hospitals for mental disease established by the legislatures of 1915 and 1917; also for the completion and maintenance of the Village for Feebleminded Women, which was authorized by the 1913 legislatures; and for the construction of additional wards and facilities at existing institutions for the mentally diseased and feebleminded. Mental examination and classification of inmates of prisons and reformatories are also being considered, as well as out-patient clinics with social service departments at state hospitals.

Rhode Island

The establishment of a psychopathic ward and an out-patient clinic for mental and nervous diseases is under advisement at the City Hospital, Providence.

Tennessee

A bill will be introduced in the legislature this session providing for the establishment of an institution for feebleminded children. The Board of Control in its recent report recommends the establishment of such an institution.

Hawaii

Legislation looking to the betterment of conditions under which mental defectives are cared for is being urged in Hawaii. The commission recently appointed to investigate the needs of the feebleminded has outlined plans to the governor.

Mexico

The national school authorities having jurisdiction over the federal district and territories, have added this year to their budget an additional 5,000,000 pesos ($2,500,000). If this sum is approved it will be used to cover the expense of truant officers, to ensure that all children of school age are attending some institution of learning, and also to found a school for backward and feebleminded children. The lack of provision for these children has been much felt. The only special schools hitherto organized have been those for the blind, the deaf mutes and the children with ringworm.

Plans for organizing state societies for mental hygiene are under way in the following states: Maine, Michigan, New Hampshire, Oregon and Wisconsin.

UNIFORM STATISTICS OF MENTAL DISEASES

The movement for uniform statistics of mental diseases has made notable progress during the past year. The classification of mental diseases, together with the statistical system based upon it, drawn up by the Committee on Statistics of the American Medico-Psychological Association and adopted by the Association at its annual meeting in May, 1917, has been approved by 145 of the 156 state hospitals in this country. Many of the larger private institutions and county and city hospitals caring for mental patients have also decided to follow this classification.

A *Statistical Manual for the Use of Institutions for the Insane*, containing the new classification, explaining the various clinical groups, and giving suggestions for the preparation of annual statistics, has been published by the Bureau of Statistics of The National Committee for Mental Hygiene. This publication is supplied without charge to the superintendent and members of the staff of each hospital adopting the classification. Standard statistical forms providing for uniform reports of administration, financial operation, movement of patients, mental diseases, etc., have been issued, and are furnished to cooperating hospitals for the compilation of their annual statistics. At the request of a number of superintendents, record cards have been printed which provide for the entering of all data called for in the statistical tables previously mentioned. These cards are being distributed at cost to all hospitals desiring them.

Although a full year has not yet elapsed since the introduction of the new system in most of the hospitals, the Bureau is beginning to receive statistical reports made out on the standard forms. While complete reports cannot be expected from all hospitals, the Bureau hopes to be able to present during the coming year a statistical review of the insane in several of the states.

MENTAL HYGIENE AT THE NEW YORK SCHOOL OF PHILANTHROPY

The New York School of Philanthropy established on January 1, 1919, a department of mental hygiene under the direction of Dr. Bernard Glueck. It is the object of this department to add to the curriculum of the School a comprehensive course in behavior and its disorders which is to be a required subject for all first-year students. The department is also planning to make possible advanced work for such second-year students as wish to specialize in psychiatric social work or in social work with delinquents. This course will be in the form of seminars and concerned chiefly with actual case work with psychiatric patients and delinquents. A syllabus of the courses offered is under preparation and will probably be available by the beginning of the school year 1919–20. Under the present temporary arrangements a course in mental hygiene is being given to a group of almost 60 practising social workers, and a course on behavior and its disorders to the regular students of the School.

RECONSTRUCTION AND THE CANADIAN NATIONAL COMMITTEE FOR MENTAL HYGIENE

The Canadian National Committee for Mental Hygiene has recently published a booklet bearing the above title, giving a brief account of the Committee's activities and the part it is taking in reconstruction.

The Committee has been assisting in the solution of the problems presented by soldiers returned to Canada from overseas suffering from mental and nervous disorders. The Invalided Soldiers' Commission invited Dr. C. K. Clarke, Medical Director of the Canadian National

Committee for Mental Hygiene, to accompany its official on his first tour of inspection of hospitals caring for military cases of mental and nervous disorders, and to collaborate with him in making a report on hospital conditions throughout the country. Improved conditions for the treatment not only of military cases, but also of civilians is likely to follow.

"For the supervision of discharged cases, the Committee suggested to the Invalided Soldiers' Commission that trained social workers be employed in various parts of Canada. This recommendation has been adopted by the Commission, and in the future, trained social workers will visit discharged men, and help by offering advice concerning occupation and personal hygiene. With such a system in operation, it can confidently be expected that relapses will become less frequent, and soldiers previously disabled by mental disorders will be materially helped in re-adjusting themselves to civilian life.

"The Invalided Soldiers' Commission is looking to the Canadian National Committee for Mental Hygiene to provide training for the social workers employed. To meet this need, the Committee is arranging a course of supervised field work and instruction in cooperation with special departments in Canadian universities."

As a result of a practical demonstration made by the Committee, one of whose workers was attached for two months to the College Street Military Convalescent Hospital, Toronto, and who proved invaluable to the staff by securing case histories, the Canadian Army Medical Corps decided to employ a social worker in Montreal and one in Toronto. A careful study has also been made by the Committee of some two hundred cases of so-called "shell shock." The observations and the conclusions from this study will be embodied in a pamphlet, which should be helpful to those engaged in treatment of military patients.

The Committee is giving considerable attention to the subject of immigration, since it has discovered that at least 50 per cent of the feebleminded and insane in Canadian institutions have come from other countries. Literature upon the subject has been reviewed, and a report is now being compiled that should be of value to the Government in shaping its policy for post-war immigration. The Committee will devote attention to the question of an efficient method of rejecting individuals with mental and nervous difficulties.

A survey of the feebleminded and insane has been conducted by the Committee in the province of Manitoba, at the invitation of the Public Welfare Commission. This investigation included all governmental, educational, and charitable institutions dealing with mental cases. A report of this study has been issued, embodying recommendations, and will be presented to the legislature in February. While the report will be of especial value to Manitoba, certain sections of it will without doubt be of general profit to all Canadians interested in social betterment.

Surveys are likely to be instituted in other provinces before long. The Committee is also planning investigations of mental abnormalities in municipalities and rural communities. A valuable body of facts has already been collected in one city, in which 4,347 cases of mental disturbance have been studied.

MENTAL DISEASES IN NEW YORK STATE

The report of the New York State Hospital Commission for the year ending June 30, 1918 shows that the total number of patients under treatment during the year, excluding transfers, was 48,037. This figure includes patients in private hospitals. Including private hospitals, there were admitted to the hospitals of the state 7,244 new patients. The state hospitals discharged 3,542 patients who were benefited by treatment. Of this number, 1,687 were discharged as recovered, 827 as much improved, 917 as improved and 111 as not insane. The percentage of patients benefited by treatment based upon all admissions was 40.7.

At the close of the fiscal year 52 of the hospital physicians were on active military duty. These comprised about one fourth of the full medical staffs of the hospitals. In like manner many of the hospital nurses entered the nursing service of the army.

The excess of patients actually in the hospital over the certified capacity is stated as 6,465. The Commission joins with the State Hospital Development Commission in recommending the erection of a new state hospital at Marcy near Utica, also for the expansion of both the Brooklyn and Creedmoor branches of the Brooklyn State Hospital. A new psychopathic hospital for the Metropolitan District is recommended. This institution would serve as a hospital for temporary care and as a research and teaching institute.

In discussing the prevention of mental disease the report states:

"In last year's report it was pointed out that progress was being made in the elimination of the causes of alcoholic insanity and general paralysis. This forward movement has continued with increasing pace during the year just past. Although in our own state the liquor traffic has not been suppressed, the number of drinking places has been greatly reduced and the amount of liquor consumed has lessened to a considerable degree.

"The effect of the decrease in the use of alcoholic liquors is seen in the reduction of admissions with alcoholic insanity. During the past fiscal year the first admissions with alcoholic insanity numbered 354, as compared with 594 the previous year.

"In order to protect the health of the army both federal and state authorities have taken active measures against venereal disease. More has been accomplished in this respect during the past year than had been done during the previous century. Cases of syphilis have been reported and appropriate means taken to prevent the infected person from infecting others. Public houses of prostitution throughout the state have been closed and laws providing for the medical examination of suspected persons and vagrants have been passed. The continuation of this important work is provided for by the establishment of a bureau of venereal diseases in the State Health Department.

"Owing to the long period that usually elapses between the primary infection and the onset of mental symptoms in syphilitic cases, the effect of these measures will not be immediately seen in the reduction of the admissions with general paralysis and cerebral syphilis to the state hospitals; but there can be no doubt that in the course of ten years such cases will be materially reduced.

"Other hopeful signs are seen in the proposed mental examination of school children and the better care of psychopathic children that will naturally follow.

"The Commission proposes to make an extensive study of the causes of dementia praecox, the form of insanity most common in the state hospitals.

"Each of the state hospitals maintains one or more clinics to which patients suffering from incipient nervous or mental disease may come for free treatment and advice. A summary of the reports of attendance at the clinics held during the year shows a total of 8,403 visits. Of these 5,098 were made by paroled patients, 568 by discharged patients and 2,737 by persons who had had no connection with the hospital. It is believed that these clinics and the social service work associated with them are effective agents for preventing some forms of mental disease and in preventing the recurrence of attacks in paroled and discharged patients."

COURSE IN SOCIAL PSYCHIATRY AT THE PENNSYLVANIA SCHOOL FOR SOCIAL SERVICE

Mental hygiene workers who watched with peculiar interest the first organized course for psychiatric social workers at Smith College last summer were even more impressed by the long reach of its influence and its indirect effects than by the training actually given there. Who shall say that educational results were not achieved when the psychiatrist who came with kindly interest or amused tolerance to lecture at Smith departed with a new realization of the value of social work and a deepened sense of the social obligation of psychiatry. Surely the socialization of the physicians and hospitals in which these students are completing their training will be of incalculable value to the mental hygiene movement. On the other hand, of even greater importance has been the carrying over to the world of social work a growing conviction of the vital contribution psychiatry has to make to this field.

The three largest societies for organizing charity in the country that have taken the responsibility of providing practice in dealing with mental cases for these students, have thereby been obliged to face with keener realization the preponderance of the mental factor in all their case-work problems. A new conception of the basis of case-work is beginning to be formulated creating a demand for workers who shall have the training to put this conception into practice.

In answer to this demand in Philadelphia, The Pennsylvania School for Social Service has planned a course in psychiatric social work open to qualified advanced students beginning February 3rd, 1919. The essential relation of psychiatry, psychology, and sociology to all case-work will be presented in lectures, conferences and demonstration clinics, with constant application and illustration in supervised field work. Great emphasis is being placed on the correlation of theory and practice. The School is giving at the same time a course in medical social service with special regard for the emergency need of social service workers in military and civilian hospitals making it possible for students to acquire medical social service training with psychiatric background.

The significant feature of the Pennsylvania School course is the shift in emphasis which has come about partly through the cessation of war but partly through a genuine growth and development of interest—the Smith course being undertaken almost entirely as a war emergency measure, the Pennsylvania School course as an outgrowth of a realization that peace even more than war needs social psychiatry.

The members of the Advisory Committee for the course are as follows: Albert C. Buckley, M.D., Philadelphia; A. A. Brill, M.D., New York; Charles W. Burr, M.D., Philadelphia; L. Pierce Clark, M.D., New York; Owen Copp, M.D., Philadelphia; Francis X. Dercum, M.D., Philadelphia; Walter E. Fernald, M.D., Waverley, Massachusetts; H. W. Frink, M.D., New York; William Healy, M. D., Boston; Beatrice M. Hinkle, M.D., New York; Smith Ely Jelliffe, M.D., New York; George H. Kirby, M.D., New York; Henry I. Klopp, M.D., Allentown, Pennsylvania; Wilmer Krusen, M.D., Philadelphia; John A. Lichty, M.D., Pittsburgh; S. D. W. Ludlum, M.D., Philadelphia; Elizabeth Spencer McCall, M.D., Bryn Mawr; E. Bosworth McCready, M.D., Pittsburgh; Edward E. Mayer, M.D., Pittsburgh; Norbert J. Melville, Philadelphia; Adolf Meyer, M.D., Baltimore; H. W. Mitchell, M.D., Warren, Pennsylvania; Jessie M. Peterson, M.D., Norristown; Kenneth L. M. Pray, Philadelphia; Francis W. Sinkler, M.D., Philadelphia; Edith R. Spaulding, M.D., New York; E. E. Southard, M.D., Boston; William G. Spiller, M.D., Philadelphia; F. S. Janney Stoddart, M.D., Philadelphia; Frances C. Van Gasken, M.D., Philadelphia; William A. White, M.D., Washington; and Major Frankwood E. Williams, Washington.

In describing the courses to be given, the prospectus states: "All social workers deal with mental cases. The need for this special training is being increasingly recognized not only by hospitals and clinics for mental diseases, but also courts, reformatories, children's agencies, and agencies dealing with families and individuals as charity organization societies, and the Home Service Sections of the Red Cross.

"Preparation for this work would ordinarily require more than twice the amount of time but in consideration of the emergency need created by the war for such workers, the School is offering the six months' training as a graduate course for those who have had an adequate foundation in college or professional work."

The class-room instruction, which is limited to two days a week, will deal with social case-work, sociology, psychology, psychiatry and field work.

The course in psychology "will present psychology from the standpoint of human behavior." Particular emphasis will be placed on the concept of mental adjustment. The practical application of a dynamic psychology to case-work will be stressed throughout. The latter part of this course will be devoted to a survey of the field of mental tests.

"Psychiatry, though originally dealing only with mental disease, has become more and more aware of the bearing of its researches on all human behavior. In psychiatry as in general medicine, hygiene, the prevention of disease, is the purpose of the psychiatrist. This course will discuss the fundamental mechanisms in their relation to normal as well as diseased minds. The various topics in the course will be treated by the leading neurologists and psychiatrists of Philadelphia and neighboring cities, each a specialist in his or her own field. In connection with this course the class will have the opportunity to see clinical types demonstrated at neurological and psychiatric clinics and to visit institutions caring for abnormal classes."

The field work will cover practically three days a week for the first five months, with social agencies in Philadelphia. During the last part of the time the students will handle mental cases. The case-work instruction will be in the hands of well-known social case-workers of Philadelphia, who approach their problems with the greatest appreciation of the contribution that psychiatry has to make to all social case-work.

SOCIAL PSYCHIATRY AT SIMMONS COLLEGE

The School of Social Work, Boston, which is a Department of Simmons College, is offering a course of ten lectures in social psychiatry to persons engaged in social work. Miss Mary C. Jarrett, Chief of Social Service of the Psychopathic Department of the Boston State Hospital, will conduct the course, and there will be opportunity for conference. Members of the course are invited to attend a series of clinics at the hospital which will illustrate the subjects of the lectures which are as follows: Mental Factors in Social Maladjustment, Dr. Lawson G. Lowrey; The Simpler Indicators of Mental Disorder, Dr. E. E. Southard; The Main Groups of Mental Diseases, Dr. E. E. Southard; Neurosyphilis, Dr. Lawson G. Lowery; Feeblemindedness, Dr. Walter E. Fernald;

Psychopathic Personalties, Dr. Edouard Sandoz; Epilepsy and Alcoholism, Dr. Abraham Myerson; Dementia Praecox and Manic-Depressive Psychoses, Dr. Lawson G. Lowrey; Psychoneuroses, Dr. Abraham Myerson; Mental Hygiene and Social Work, Miss Mary C. Jarrett.

SMITH COLLEGE TRAINING SCHOOL FOR SOCIAL WORK

Last summer Smith College, under the auspices of The National Committee for Mental Hygiene and in cooperation with the Boston Psychopathic Hospital, offered a course of training for psychiatric social workers to meet the anticipated demand for social workers in neuropsychiatric wards of army hospitals. The Training School for Social Work, which will be opened at Smith College, July, 1919, is an outgrowth of this course and is an endeavor to meet the demand for trained social workers in several fields in which increased activity is to be expected during the reconstruction period. The following courses are offered: (1) A training course in psychiatric social work; (2) a training course in medical social work; (3) an advanced course in child welfare open to persons already engaged in social work for children; and (4) a training course in community service.

Graduates of colleges will be admitted to the training courses and, according to their preparation, will be required to take an eight weeks' summer session of didactic work, followed by six months of field practice, or a longer course of two consecutive summer sessions, with an intervening period of nine months of field practice. Social workers will be admitted to all courses for the summer's work; and teachers may be admitted to the courses on child welfare, community service, and combinations of the others.

The psychological and psychiatric points of view will be stressed in all four sections. Base courses in psychology, sociology, and principles of social case-work will be required of all students. Those in training for psychiatric social work will specialize in social psychiatry; those preparing for medical social work will specialize in social medicine; those interested in child welfare will study especially child psychology and problems of child welfare; and those preparing for community service will specialize in social psychology and community organization. Each section will be under a group leader who is a social worker with experience in that particular field, and the medical branches will be taught by experienced physicians with the assistance of visiting lecturers eminent in special fields of medicine and psychiatry. The field work will be done in psychopathic hospitals, general hospitals, and settlements in various cities, under the oversight of the group leaders.

The Director of the Training School, Dr. F. Stuart Chapin, professor of sociology in Smith College, has been for a number of years in direct contact with the practical field of social work, and took a major part in the training school of psychiatric social work held at Smith College last summer. Miss Mary C. Jarrett, Chief of Social Service in the Boston Psychopathic Hospital, who directed last year's course, will be associate director of the new school. The course in psychiatric social work will again be under the auspices of The National Committee for Mental Hygiene represented by the same committee that served last year, the members of which are as follows: Dr. E. E. Southard, Chairman; Dr. William L. Russell; Dr. L. Pierce Clark; Dr. Walter E. Fernald; and Dr. William A. Neilson.

Thirty-seven graduates of the 1918–1919 school will be ready for positions in psychiatric social work this spring, in addition to ten who had already done the required practical work and who entered positions at the end of the summer. After the summer's work several students were dropped, and a few others were obliged by circumstances to discontinue. During the practice period, eight dropped out—two on account of illness, two because of unfitness for the special type of work, two because of family demands, and two to do other work. Twenty-seven of the forty-seven graduates, at this writing, have accepted positions or are already occupying positions, and by the end of their term, March 1, it is likely that all will be scheduled for positions. The majority of the graduates will probably be placed in military hospitals; but the demands of civilian work have made inroads on their number, and the increase in psychiatric social work to be expected in connection with reconstruction programs for mental hygiene will make this group of specially trained social workers quite inadequate in number.

The course in psychiatric social work offered by the new Training School will be similar to the previous course, with slight modifications, and with the additional opportunity for longer preparation through three more months of field practice and a second summer session of advanced didactic work.

ARCHIVES OF NEUROLOGY AND PSYCHIATRY

Under the above title, the first number of a new monthly journal devoted to mental and nervous diseases has been issued. It is the result of the request of about one hundred leading neurologists and psychiatrists to the Board of Trustees of the American Medical Association to undertake the publication of such a journal. Its purpose is to meet the need for "a scientific publication of high ideals which shall not only serve the purpose of the research man and technical expert, but which shall also be of immediate practical value to the clinician."

The following list of articles in the first number gives a general idea of the scope of the magazine:

The Military History of the American Neurological Association, Presidential Address. Theodore H. Weisenburg, M.D., Philadelphia

The Treatment of War Neuroses. Sir James Purves Stewart, M.D., F. R. C. P., London

War Neuroses: Some Views on Diagnosis and Treatment. Colin K. Russel, M.B., Montreal, Canada

The Histogenesis of Multiple Sclerosis. Theophil Klingman, M.D., Ann Arbor, Michigan

So-Called Shell Shock: The Remedy. Francis X. Dercum, M.D., Philadelphia

Complete Division of the Spinal Cord in Lower Dorsal Region. A Case with Conservation of Spinal Reflexes Below Level of Lesion. W. F. Schaller, M.D., San Francisco

Neuropsychiatry in Recruiting and Cantonment. M. S. Gregory, M.D., New York

The Genera in Certain Great Groups or Orders of Mental Disease. E. E. Southard, M.D., Boston

The editorial board consists of Dr. Hugh T. Patrick, Chicago; Dr. E. E. Southard, Boston; Dr. August Hoch, Montecito, California; Dr. Frederick Tilney, New York; Dr. T. H. Weisenburg, Philadelphia.

Connecticut Society for Mental Hygiene

The eleventh annual meeting of the Connecticut Society for Mental Hygiene was held in New Haven, December 12, 1918. Mr. Robert W. Kelso, Secretary of the Massachusetts State Board of Charities, delivered an address on the topic, "Next Step in the Mental Hygiene Movement." Mr. Kelso emphasized particularly the relation of mental defect to pauperism and the necessity of a "business-like educational campaign that shall bring the public to see that there is no escape from the astounding increase in poor relief yearly confronting us until we begin a plan of stopping it at the source." The question of venereal diseases as related to mental defect was also presented. The speaker pointed out the necessity of immediate measures to conserve mental health, urging for Connecticut a system of state care for mentally defective and mentally diseased.

The Indiana Society for Mental Hygiene

The third annual meeting of the Indiana Society for Mental Hygiene was held in Indianapolis, December 16, 1918. The topic of the morning session was "Mental Health and the Family," the speakers being: Eugene C. Foster, Indianapolis; Mrs. Albion Fellows Bacon, Evansville; Dr. O. C. Higgins, Lebanon; and Miss Helen Andrews, Indianapolis. An address was given by Miss Helen T. Reeves of Bridgeton, New Jersey on "The Technique of the Survey," followed by the address of the President, Dr. William Lowe Bryan of Bloomington. "Mental Health and the Community" was the topic of the afternoon session and the following speakers took part in the discussion: Miss Edna R. Jatho, Philadelphia; Prof. R. W. Himelich, Fort Wayne; Dr. George S. Bliss, Fort Wayne; Miss Rhoda M. Welding, Indianapolis; Dr. Earl Palmer, Logansport;

and Dr. W. C. Van Nuys, New Castle. In the evening the speakers were as follows: Dr. Charles P. Emerson, Indianapolis; Major Frankwood E. Williams, Washington; Miss Jessie Binford, Chicago; Miss Marion E. Nash, Dover, N. H.; Starr Cadwallader, Columbus; and Miss Ann Todd, Indianapolis. "Mental Health and the Army" was the topic of the evening session.

The officers of the Indiana Society for Mental Hygiene are as follows: President, William Lowe Bryan, Bloomington; Vice-President, T. F. Fitzgibbon, Muncie; Secretary, Paul L. Kirby, Indianapolis; Treasurer, Evans Woollen, Indianapolis; and Chairman, Executive Committee, Amos W. Butler, Indianapolis.

MASSACHUSETTS SOCIETY FOR MENTAL HYGIENE

The annual conference of the Massachusetts Society for Mental Hygiene was held in Lorimer Hall, Tremont Temple, Boston, January 16, 1919. At the afternoon session, Hon. Frederick P. Cabot presided, and the program was as follows:

Mental Hygiene, War and Education

1. The Need and Opportunity for Mental Hygiene as Shown by the War, *Major Frankwood E. Williams, Medical Corps, U. S. A.*
2. The Need for Instruction in Mental Hygiene in Medical, Law and Theological Schools, *H. Douglas Singer, M.D., State Alienist, and Director, Illinois State Psychopathic Institute*
3. The Smith College Experiment in Training for Psychiatric Social Work, *W. A. Neilson, LL.D., President, Smith College*

The President of the Society, Prof. William H. Burnham, presided at the evening session, at which time the subject "Mental Hygiene and the Education of the Young" was presented. Addresses were made by Prof. Arnold Gesell, Prof. Walter F. Dearborn, and Dr. C. Macfie Campbell, which are published in this number of MENTAL HYGIENE, as are the papers by Dr. H. Douglas Singer, and President Neilson, read at the afternoon session.

MENTAL TESTS FOR COLLEGE ENTRANCE

The faculty of Columbia College, representing the undergraduate department of the University, recently voted to apply the principles of the selective draft by means of mental tests in measuring the fitness of applicants for admission. It is intended to abolish the old-style entrance examinations, and substitute tests to measure the student's intelligence and mental ability. The tests will be similar to those used for applicants for the Students' Army Training Corps and will be used for the academic year beginning next September.

FOR MORALE—IN SEASON AND OUT

"Questions of morale have been far to the front in these years of the testing of nations, and mental balance and staying power have come to be recognized for their full importance among the factors which lead a country to constructive achievement. This 'national morale' of which so much has been said—this force which carries liberty loan campaigns over the top, which supports through thick and thin a country's soldiery—is, of course, only an embodiment of the morale of millions of a nation's individual citizens. It can rise but little higher than the general level of the separate minds and hearts which enter into it. It can make no progress at all in quarters where the door is barred against its admission. It is most perilously open to injury through the efforts of a single unsound mind, or group of minds, at work among a nation's millions, even as the mind of a Liebknecht, once clear and forceful in its championship of liberty against despotism, but now unsettled and enfevered by years of persecution and bitterness, is today threatening Germany with a fresh disaster piled upon the disaster to which the Hohenzollerns led her.

"A nation's need of mental health is, indeed, as plain as the need that there should be at work, in season and out of season, in time of peace as in time of war, agencies having regard for the mental health of the individuals comprising a nation. In the broad sense of the word the schools, the colleges and the churches of the country are all engaged in this task. There is one agency, among others in this state, which takes this labor, however, as its particular business, bringing together expert information and counsel on the subject which it makes available to all the other groups engaged in this task. We mean the Massachusetts Society for Mental Hygiene. The subjects which it announces for the afternoon and evening meetings of its annual conference on Thursday next are deeply suggestive of the purposes which it is pursuing. They are 'Mental Hygiene, War and Education' and 'Mental Hygiene and the Education of the Young.' The authoritative and representative character of the speakers whom it will bring together for these two meetings are observable at a glance, for they comprise delegates from the Surgeon-General's office, The National Committee for Mental Hygiene, the Smith College training school for psychiatric workers, and from the great university departments of education or child hygiene at Harvard, Yale and Johns Hopkins.

"The whole structure and program of the two meetings are of large public interest and make for the preservation of morale in season and out."—Editorial, *The Transcript*, Boston, January 11, 1919.

MENTAL HYGIENE

"The Massachusetts Society for Mental Hygiene, which has its annual conference in Boston tomorrow, is an organization which addresses itself to the solution of problems and to the doing of work of a nature that the growing complexity of modern social life, makes more needed than ever.

"It may be said, however, that the words, 'Mental Hygiene,' have not yet gained a familiar sound and it is, as a matter of fact, only in recent years that there has been gained knowledge enough to make social application of the principles of mental hygiene—learned largely through study of the lives of sufferers from mental and nervous disorders and defects. Endless thought and care has been given to bodily hygiene; but to the thing that lies even nearer, mental health, upon which depends not only the welfare of our bodies but the success or failure of our entire lives, little attention has been given. Most people know that mental attitudes, habits, prejudices and the like go very far towards determining the happiness or unhappiness of human life, but it has not been clear until lately how much could be done educationally about it. The Massachusetts Society for Mental Hygiene is organized to put before the community what, with knowledge as it stands today, may be done towards the mental health of individuals and of society, and to promote further study in this direction.

"A single quotation from William H. Burnham's *Mental Health for Normal Children* illustrates personal mental hygiene of the kind that may best be taught the young in home and school. He says: 'in moral and emotional training, children should be taught to live one day at a time, to settle their moral accounts every night, never to hold a grudge, never to let the sun go down upon their wrath, to look upon each morning as a new day in which to improve, but not to carry over their troubles from yesterday.'

"The other aspect, mental hygiene in the social or group sense, is most familiarly illustrated by the great movement towards extension of care of the feebleminded, so clearly indicated in the recent message of Governor Coolidge—both care for those of the feebleminded who need institutional provision such as is now given through the State Schools at Waverley and Wrentham and for those who may safely live in the community if understood—an educational field in which valuable work has already been done through private agencies, public clinics, special classes in the public schools and such departments as the Girls' Parole Department and the Juvenile Courts.

"Another aspect of mental health, in the group sense, is illustrated by the countless questions of sanity and everyday democracy that arise in community life. Irving Fisher recently referring to the great danger of discontent among laboring men when workers return from the soldier's life, notes that some economically have come to the conclusion that 'the solution of the problem of industrial discontent . . . will lie along the lines of making the workman genuinely interested in his work.'

"Such is the range of problems of mental hygiene. The Massachusetts Society appears to be on the track of things that promise a real contribution to the difficult business of daily living. The better understanding alone, of the human mechanism, along those lines, will surely be a good thing for individuals and for the community. In these times of stress and uncertainty such messages, put in plain and helpful terms, will be welcomed by all, but especially by parents and teachers."—Editorial, *Worcester Evening Gazette*, January 15, 1919.

RECOMMENDATIONS OF THE NATIONAL COMMITTEE FOR MENTAL HYGIENE FOR THE STATE CARE OF THE FEEBLEMINDED IN KENTUCKY

I. *Farm Colonies*

1. Farm colonies for the permanent care of feebleminded persons are recommended as the most effective single means now available for preventing these persons from having large numbers of feebleminded children. Many of the feebleminded are more prolific than the average population, and large numbers of their children are public charges on account of their mental defects.

Taken in hand early in life they must be trained to work with their hands. This will bring out in the best way possible, and to the highest degree, all the powers they possess. Being thus trained and provided with work, they will be made as happy as possible—much happier than living in idleness with incompetent relatives—and, what is most important from the point of view of public policy for this class, they will, as a class, be made in time to a considerable degree self-supporting.

2. A farm colony affords the occupations best suited to interest and bring out the best from the feebleminded of both sexes. The simple arts of the household and the farm—caring for plants and animals, raising and preparing materials for food, clothing, and shelter—are always interesting to children. The feebleminded are in effect children and they remain children in mind. Their minds cannot grow up. They can, therefore, be most easily and effectively cared for in the simpler occupations of the farm.

3. Such training and care cannot be provided at county poor farms, and it is not provided by the state pensions to pauper idiots. Both of these favor the propagation of the feebleminded, increasing the burden from this source for posterity. County poor farms should be prohibited caring for feebleminded; pauper idiot pensions should be discontinued and the money spent for effective training and custody in segregation of mental defectives.

II. *Buildings*

Buildings of not more than two stories are recommended. These should be of size suitable for housing from fifty to one hundred persons, each providing dormitory, day-room, dining-room, and kitchen. Such small groups approximate family conditions and are as economically cared for as in the larger and more usual institution type of building. This type of building presents the possibility of easy segregation of different types of persons. Not only must the "boys" and "girls" be kept apart, and the negroes from the whites, but the low grade (except as higher grades are used for attendants), the delinquents and those who cannot be allowed ordinary liberties, and the epileptics must each have separate quarters.

The buildings should be constructed of concrete blocks, bricks, or other material which can be manufactured by the feebleminded on the farm.

III. *Kind of Land and Its Location*

1. It has been demonstrated in Massachusetts and New Jersey, as well as in other states, that feebleminded labor can put into a good condition of fertility run-down and unimproved land. If the colony for feebleminded is to be made approximately self-supporting, the soil selected for the purpose must have in it capacity for response to tillage and fertilization. Barren or near barren land must not be selected. But it is not necessary to incur the expense of purchasing for this purpose the best or anywhere near the best land in the state. The land should be good but cheap on account of neglect or location.

2. The location should be far enough away from cities that it can be purchased for its inherent agricultural value, but not so far as to be inaccessible.

3. Ease of communication with all sections of the state from which the population of the colony is expected to be drawn, should be a weighty factor in deciding upon the location of such colony. The more accessible the feebleminded person is to be to his family and friends when in the institution, the more readily will the latter consent to such care. Much of the success, therefore, of the state policy to segregate and train all feebleminded persons will depend upon the location of the colonies.

IV. *Number of Colonies Needed for Adequate Care*

Kentucky should plan for the ultimate establishment of three colonies. The contour of the state, the distribution of the population, the railroad facilities of the state, and the number of feebleminded persons to be taken care of, indicate the advisability of locating one institution toward the western end of the state, one in the northeastern section, and one in the southeastern or south central portion.

V. *Training the Feebleminded*

For their own greatest happiness and in order that they may eventually become in part self-supporting, the feebleminded must be specially trained when young. The subjects ordinarily taught in the public schools are of little use to them and are, indeed, beyond their ability to learn. The feebleminded find their joy and self-expression in working with their hands. They must get such training in special classes in the public schools, or they must go as children to the state colonies. For these the farm colony must have a training department. The teachers connected with the colony must be specially trained for work with the feebleminded.

VI. *Medical Superintendent*

These peculiar training problems, the organization of the whole colony for most effective living, and the many definitely medical problems involved, demand that the direction of the institution be placed in the hands of a physician. This physician must be a person specially trained in the care of mental defectives. He must know them through long and intimate association with them.

VII. *Epileptics*

There are a large number of epileptics in the state. Many of these are now pensioned by the state. No class of dependents call more loudly for institution care and medical treatment. The cottage plan of institution under medical supervision, as outlined above, removes necessity for considering a separate state hospital at this time. The colony as planned can make them as comfortable as possible, and can effectively study the causes of the condition with a view to lessening the frequency of its occurrence. As a permanent policy, however, provision for the feebleminded and epileptic in the same institution is not to be recommended. Kentucky should eventually provide a separate institution for epileptics.

VIII. *Department of Research*

Each colony should maintain a department of research in which would be carried on investigations into the causes of mental defect.

Expenses for such research is money spent by society to prevent waste. It is like the stitch in time. Such research is comparable to that of the chemist in utilizing waste products. It is bound to produce large returns on the investment. It is essentially social salvage.

IX. *Early Diagnosis*

The facilities for early diagnosis—in the public schools, the juvenile courts, the homes for dependent children—should be widely extended.

X. *Special Classes in the Public Schools for Mentally Defective Children*

In the interests of the normal as well as the defective child, the latter should be identified early and given instruction in special classes. The formation of special classes for the mentally defective in the public schools should be encouraged throughout the state.

XI. *Supervision*

Many feebleminded, if properly trained at an early age in special classes in the public schools, or in the training departments of state colonies, need not become permanent custodial charges if adequate supervision is provided in the community. To be adequate, however, this supervision must be organized, must be close, and under the direction of those who have understanding of the feebleminded and are accustomed to dealing with them.

XII. *Registration*

For the ultimate solution of the problem, registration of all the feebleminded, with life-long supervision either in the community or in the institution, is necessary. A complete register will be a matter of gradual growth and development, but will be made possible in time as the agencies in the public school and elsewhere in the community are better able to identify early those who are defective. At one time or another practically every feebleminded child in the state comes in contact with some organized agency of the state—the school, the court, the children's homes, the charitable societies—and if at this contact provision for identification is provided (and in all of these agencies the problem is of such magnitude as to warrant such provision), registration becomes a simple matter. The registration of all the adult feebleminded now in the state is probably not possible; but such a registration is not essential. If the State of Kentucky will provide adequate care for those now known and identified in the community, and will at the same time increase her facilities for early diagnosis and register year by year of those defective children who, as they advance toward adolescence, come in contact with her social agencies at one point or another, the State of Kentucky will steadily gain in her control of the problem of feeblemindedness as it exists within her borders.

XIII. *The Commitment of Mental Defectives*

To secure the custody and proper management of the mental defectives of the state, legal provision must be made for diagnosis and commitment, as well as parole and discharge, of the feebleminded. Courts must be afforded the help of well-qualified physicians in making decisions bearing upon the management of such persons. Appeal for jury trial should, of course, remain an inviolable right under the state constitution, but it must be recognized that such cases are not primarily for trial, but for diagnosis. Once the case is known for what it is, the judge and doctors are best able to decide what disposition of it is most likely to bring the greatest benefit to the individual and to the community.

XIV. *Commitment of the Insane*

When a rational and socially effective method is provided for the commitment of the feebleminded, it is important that the insane—the temporarily incompetent—shall have the same or equally suitable methods provided for their commitment, temporary care, parole, and discharge afforded them. The mentally sick are more seriously damaged by mishandling by police and courts than are the feebleminded. They need nursing and every sort of rational aid to return them to their normal health and usefulness.

THE WAR'S LESSONS IN MENTAL HYGIENE

"The war has greatly increased the scope of mental hygiene, and on the other hand, mental hygiene has made contributions of vast importance and unprecedented character to the war. One of the most striking of these has been the expert examination of officers and men for the detection of nervous and mental disorders. This, without question, has resulted in preventing the death and disablement of countless soldiers through the weeding out of the unstable feebleminded, psychopathic, epileptic and insane. It has obviously also greatly increased the efficiency of the army.

"At the same time this rejected material thus turned back into the community has disclosed to a degree never revealed before, the large extent of unsuspected mental disease, instability and defect existing in the world about us. It would, therefore, seem to open up a new field for practical philanthropic work in the possible relief of many of these cases, and the consequent protection of the public. . . ." —Editorial, *The Sunday Herald*, Boston, January 12, 1919.

PRACTICALLY ALL CASES OF "SHELL SHOCK" RECOVER

The elimination at cantonments of men nervously and mentally unfit for military service, and the successful early treatment of neuroses in the advanced stations in the American Expeditionary Forces, have made "shell shock" an almost negligible after-war problem in the United States. In this connection the following letter, by Major Frederick W. Parsons, Commanding Officer, Base Hospital No. 117, American Expeditionary Forces, taken from the European edition of the *New York Herald*, is of interest:

"In a recent copy of the *New York Herald*, there appeared an article concerning Base Hospital No. 117, A. E. F., which gives an entirely incorrect account of the outcome of cases of war neuroses. The article conveyed the idea that no one recovered sufficiently to perform military service in France, when, as a matter of fact, practically all recover.

"After a nearby shell explosion, a short period of trembling is not unusual. This may last only a few minutes or a part of a day, and ordinarily these patients are returned to duty by the battalion and regimental medical officers. When the stage of absolute exhaustion is reached, nervous symptoms are likely to develop. These cases usually reach the *triage*, from which place a large percentage return to duty. Forward neurological stations receive and return to duty many of the cases that have been evacuated from the more forward areas and this hospital receives only those severe cases passed on by three other medical posts, cases which are not expected to recover speedily.

"With these cases the hospital returns to duty the following percentage:

Class A*	19 per cent
Class B	44 per cent
Class C	32 per cent
Class D	5 per cent

"Thus, 19 per cent are ready for immediate combat duty, an additional 44 per cent presumably will be ready after a short interval, making a return to the line of 63 per cent, with 32 per cent more, 95 per cent in all, capable of rendering A. E. F. service. Only 5 per cent return to the United States and even they are not incurable, return indicating in this instance a duration too long to warrant continued care in France.

"A war neurosis which persists is not a creditable disease to have, as it indicates in practically every case a lack of the soldierly qualities which have distinguished the Allied Armies, and it will not be a serious problem. The population of the United States will easily absorb the few scores of unrecovered cases that will exist after the expiration of six months of peace, and no one should be permitted to glorify himself as a case of 'shell shock.' It should become widely known that a persistent war neurosis is not something of which to be proud. It is not the same as an honorable wound. A temporary state of a few days' duration from which a person quickly recovers is not discreditable, but if the symptoms persist after rest and treatment, then it is a disorder of the will, and one does not boast of a weak will. In an army of perfect men there would be no 'shell shock' problem."

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*A-Front Duty; B-Temporary Base Duty; C-Permanent Base Duty; D-Return to United States.

ABSTRACTS

THE SCOPE AND AIM OF MENTAL HYGIENE. By WILLIAM H. BURNHAM. *Boston Medical and Surgical Journal*, 179: 749–55, December 19, 1918.

Mental hygiene is no longer concerned merely with the care of the feebleminded and the insane. While in the minds of some it may still be associated with certain fads and vagaries, it now rests on a solid foundation of scientific fact, and has already made important contribution to the mental health of normal children and adults. Recent studies have greatly increased the scope and significance of the subject.

The author dwells at length upon the relation of mental hygiene to war, showing how war has increased the scope of mental hygiene and how mental hygiene, in turn, has contributed to the conduct of the war, in its examination of officers and men to detect nervous and mental disorders, in the reeducation of the disabled soldier, and its aid to the morale of the army.

"Again, the effect of the war upon children suggests the need of sound mental hygiene. Investigations indicate that children in the war zone are largely protected from fear and worry by their natural attention to the present and the concrete details of any situation, however terrible, but in prolonged wars the strain has its effect. One of the saddest reports of the Thirty Years' War was that the children were no longer seen playing in the streets of the German cities; and in some localities in the present war it has been said that the children have forgotten how to smile."

The importance of the lessons of war in regard to nervous disorders is emphasized. The cases of war neurosis show what may happen to any individual if subjected to sufficient strain. The author points out, by a quotation from G. Elliott Smith, the relation between war neuroses and disorders found in times of peace, as follows:

"The incipient forms of mental disturbance which the anxieties and worries of warfare are causing ought to impress upon the attention of everyone that such causes are also operating both in war and peace, and are responsible for a very large proportion of the cases of insanity, and it is precisely these cases which, if diagnosed in the early stages and treated properly, can be cured. The chief hope of reducing the number of patients in asylums for the insane lies in the recognition of this fact, and acting upon it in the way of providing institutions where such incipient cases of mental disturbance can be treated rationally, and so saved from the fate of being sent into an asylum."

The public school, the author believes, is a place where principles of mental hygiene should be applied, and training given that is adapted to individuals likely to develop nervous disorders. Teachers should be given adequate preparation for such work, and time and attention should be devoted to the detection and care of such children. As a logical sequence, demand would be made that all children have the benefit of mental hygiene and that all teachers have a knowledge of the subject and follow its principles in all methods and discipline of the school.

Mental hygiene has been placed upon a scientific basis through physiological studies. Investigations have shown physiological changes to be related to mental work, such as variations in the distribution of the blood, an increased liberation of heat and greater metabolism. A vast literature has been recently produced on the subject of the glands with internal secretion. These studies show that normal growth and development depend upon the proper functioning of these glands, that certain forms of feeblemindedness are caused by defects in one or more of them, and that their normal functioning is significant in our life of feeling and action. These glands apparently not only regulate growth but are to be especially considered in the hygiene of emotion.

"Recent studies in psychiatry have also greatly broadened the field of mental hygiene. They have shown the possibility of preventing many forms of mental disorder; especially cases on the borderline between the normal and the defective, cases of the manic-depressive type, the various anxiety neuroses and fatigue psychoses, and even some cases of dementia praecox, where suitable environment and suitable training can be provided. They have shown that in many cases the best means of cure is some form of reeducation involving the development of wholesome interests and regular habits of attention and orderly association. This method, so helpful for cure, appears even more significant as a means of prevention; and thus is opened a wide field for the work of mental hygiene, especially among children and youths. It is a grave reflection upon the schools that so many of their graduates have to be reeducated in the sanitarium or the hospital."

The author recognizes the many important contributions to mental hygiene made by psychology in recent years. He says: "These investigations have shown that deeper than the life of perception and ideas are the mental tendencies, the sets of the mind, the mental attitudes, and the like." The importance of mental attitudes is emphasized. These are determined not only in the home but in the school. The mental attitude of the pupil helps to determine his mental efficiency and also his mental health. The author believes that many cases of mental disorder could be prevented by the proper attitudes toward life.

The scope of mental hygiene has been widened by the investigations in experimental psychology. The author emphasizes the importance of the modern study of the conditioned reflex and its adaptation to the study of children. The difference between an ordinary reflex and a conditioned reflex is pointed out by the following illustration: "If I give a dog a piece of meat, at once there is a flow of saliva. That is an ordinary reflex. Pavlov has shown that, if every time one gives the dog meat a bell is rung, after a time the mere ringing of the bell without giving meat will produce the flow of saliva. This is a most remarkable result. An entirely indifferent stimulus, the sound of the bell, has become associated with the biologically adequate stimulus, the meat, and produces the same physiological reaction. The flow of saliva brought about by the mere ringing of the bell is a conditioned reflex, and the sound of the bell is called a conditioned stimulus."

Krasnogorski in Russia, Dr. Florence Mateer at Clark University, and Dr. John B. Watson at Johns Hopkins have shown that motor conditioned reflexes can be developed in children and that the ability to form such reflexes is correlated with the development of the mind and brain. Training in animals and children consists largely in the acquisition of conditioned reflexes. An example is also given to show the production of an unfortunate conditioned reflex.

"Another class of investigations partly psychological and partly psychiatrical, namely, the studies in psychoanalysis made by Freud and his followers, have contributed much to mental hygiene, by showing the great importance of normal emotional and instinctive life in early childhood, the persisting evil results that may come from any unfortunate emotional shock, even in the days of infancy, and the danger from abnormal domestic relations—undue dependence on father or mother, undue repression by the parents, or the like.

"These studies are significant not so much because the psychoanalysts have shown the widely irradiated effects of disturbances of normal emotional life, but because this work furnishes illustration of the great principle that opportunity for normal reaction to emotional or instinctive stimuli should be furnished, and of the pathological effects that may occur when such opportunity is not given.

"In spite of somewhat erratic terminology and sometimes fantastic illustrations, Freud has also made important contribution to the general and applied psychology of feeling and association. Just as Pavlov and his school have shown that any sensation whatever from any receiving organ may become associated with an ordinary stimulus and bring about precisely the same physical reaction, so the studies of Freud apparently have shown that in some cases at least, when a normal reaction is blocked, any kind of a reaction, physical or mental, associated with the ordinary reaction may take its place and function vicariously."

The functions of a mental hygiene society may be briefly summarized as follows:

1. "The care and prevention of feeblemindedness and mental disorder, the traditional function of such societies, for which they were first organized. This, of course, should be continued.

2. "Care for defective delinquents and the large class of other defectives found in every school.

3. "Care for the mental health of normal children, a function that cannot be too strongly emphasized.

4. "The development of every-day patriotism and every-day democracy, and care for the mental health and morale of our citizens and of the soldiers and sailors in our army and navy.

5. "Care for the mental health of all those who, in this present time of stress, are subjected to unusual burdens and anxieties.

6. "Care for the wounded and discharged soldiers who are returning from the war with nerve shock and the like."

"The social service that can be rendered in the field of mental hygiene is of two kinds, help for individuals and aid to social groups. It is not merely a matter of developing honor, loyalty, self-control, interest in work, and the democratic spirit among individuals, but also a question of mental health, sanity and the democratic spirit in social groups. Irving Fisher recently referred to the great danger of discontent among laboring men when workers return from the soldier's life, and he notes that some economists have come to the conclusion 'that the solution of the problem of industrial discontent . . . will lie along the lines of making the workman genuinely interested in his work.' The mental hygiene societies may well cooperate in developing wholesome interests in this great social group. . . ."

"Nothing better for the welfare of Germany could have happened than a thorough defeat. In her present pathological condition it gives her the opportunity for healthful reeducation. To the allied nations, the most serious crisis since the first battle of the Marne has now come. As Clemenceau has recently said, it will be harder to win peace than to win victory. For America the present represents a period of gravest danger of those extreme and unrelated developments which threaten the health and sanity of the nation. In helping to meet this danger and in aiding educational reform lies the greatest opportunity that has ever existed for mental hygiene."

The author gives a brief account of the aims and activities of the Massachusetts Society for Mental Hygiene, of which he is President, emphasizing the fact that the Society has from the beginning attempted "to combat mental disease from the point of view of prevention."

In conclusion he writes: "Such is the scope of mental hygiene. Such is its message. In a time when the danger of mental disorder is more serious, perhaps, than ever before, and the number needing the help of a sound mental hygiene greater than ever before; when we are just emerging from the storm and stress of war; when the hearts of men and women at home are still bearing heavy burdens and the morale of the best soldiers is being tested by a strain more severe than that of war; in a time of numerous fads and cults, when men cry, 'Lo, here, and lo, there, is the kingdom of health,' mental hygiene preaches its quiet gospel based upon scientific fact and offers the aid of our vastly increased knowledge to those in need of sympathy and aid, a gospel as significant in peace as in war, as important for children as for adults, as helpful for normal children as for the defective."

PSYCHIATRIC MATERIAL IN THE NAVAL PRISON AT PORTSMOUTH, N. H. By A. L. JACOBY, M.D. *United States Naval Medical Bulletin*, 12: 406–13, July 1918.

Along with the great increase in the personnel of the navy due to the war, has been a continuous growth of its prison population. The number of general court-martial prisoners at Portsmouth, N. H., February 1, 1918, was 1,646—an increase of over 650 per cent since April 1, 1917. The population is increasing at the rate of 200 per month, which equals the total prison population on April 1, 1917.

"The naval prison is exactly similar to any state prison in that its inmates are there because they did something which the law says they must not do. The character of the man himself and the reasons for the commission of the forbidden act are too frequently not considered when he is sent to prison. An offense, military or moral, may have been committed for any number and variety of reasons, and there is in every case a reason. Very frequently, indeed, the act represents the more or less natural conduct of a disordered mind. The percentage of the mentally abnormal amongst prison population in general has been variously given by different writers." Dr. William A. White in his *Principles of Mental Hygiene*, says: "A considerable proportion of the prison population are, however, not normal in their developmental possibilities. Upward of 50 per cent as they are admitted have demonstrable disease at the central nervous system level. That is, they are mentally defective, psychotic, or have gross central nervous system disease, such as arteriosclerosis or syphilis. This does not include bodily diseases other than that of the central nervous system."

About November 1, 1917, psychiatric examination of naval prisoners was undertaken to determine the frequency of nervous disorders among court-martial prisoners and to find a way to prevent the loss of so many men to the service. A careful family and previous history of 150 men was taken from the prisoners personally and the facts corroborated wherever possible. The Terman measure of intelligence was used; the men were examined neurologically and psychiatrically; in doubtful cases they spent an observation period in the naval hospital; special examinations were also made—cerebro-spinal fluid, eye grounds, Wassermann, X-ray, etc.

Of these 150 cases, 75 were referred for examination by prison officials, 3 reported of their own accord, and the remaining 72 were examined in routine.

There were 25 different offenses represented and 156 arrests, some of the men having been sentenced for more than one offense. Fifty-six per cent of the total offenses were of a military nature and would not have taken the man before a civil court. Fifty per cent of the men had been in the service less than six months when they arrived at the prison, 49 more than six months but less than one year, and five had served more than a year. The nature of the offenses is shown by the following table:

TABLE 1

Offense	*Number*	*Per cent*
Desertion	53	31.9
Absence over leave	37	22.2
Scandalous conduct tending to the destruction of good morals	11	0.6
Absence without leave	9	0.5
Assault	8	0.4
Sodomy	7	0.4
Conduct to the prejudice of good order and discipline	6	0.3
Disobeying lawful order of superior officer	5	0.3
Drunkenness on duty	5	0.3
Theft	5	0.3
Sleeping on post	5	0.3
Threatening to strike superior officer	2	0.1
Murder	1	0.06
Fraudulent enlistment	1	0.06
Leaving post before being regularly relieved	1	0.06
Striking and wounding a person in the navy	1	0.06
Absent from station aboard ship	1	0.06
Forgery	1	0.06
Refusing to obey lawful order of superior officer	1	0.06
Destruction of public property	1	0.06
Unlawful possession of property belonging to another	1	0.06
Breaking arrest	1	0.06
Neglect of duty	1	0.06
Using obscene and profane language toward another person in the navy	1	0.06
Falsifying accounts	1	0.06

Table 2 shows the cases by diagnosis. Two thirds of the total number examined will be seen by this table to have nervous or mental disorders.

TABLE 2

Diagnosis	*Number*	*Per cent*
Subnormal	34	22.6
Hysteria	18	12.0
Dementia praecox	3	2.0
Manic-depressive insanity	2	1.3
Anxiety neurosis	2	1.3
Paranoid state	1	0.6
Depression (undifferentiated)	1	0.6

TABLE 2—*Continued*

Diagnosis	*Number*	*Per cent*
Epilepsy	2	1.3
Chronic alcoholism	6	4.0
Cerebro-spinal syphilis	3	2.0
Psychopathic personality	8	5.3
Constitutional inferiority	9	6.0
Congenital syphilis	1	0.6
Neurological:		
Tabes dorsalis	1	0.6
Nerve injury	1	0.6
Migraine	1	0.6
Unclassified	7	4.6
No psychiatric condition	50	33.3

In the group of 34 subnormals, there were found to be 17 different offenses. Seventy per cent of the offenses in this group were of a military nature, most of these being of a kind to be expected of the feebleminded. "For example, a boy 19, four months in the service, in leaving his ship for the usual overnight liberty, asks one of his companions if 'it would be all right for him to go home for a week,' and when his shipmate replies that he 'can if he wants to,' stays home a week and returns to find himself charged with absence over leave."

The hysterics were the second largest group, and five of the eighteen cases developed in prison. Two of these were "twilight states," sometimes classed as prison psychoses. The five cases that developed in prison were sentenced for moral offenses, the remaining thirteen for military offenses.

The six cases of chronic alcoholism were between 24 and 34 years of age, older than the average of the prisoners. Each had a long history of excessive use of alcohol, and two had been committed to state hospitals as inebriates prior to enlistment.

Among the eight cases of psychopathic personality were six of the so-called "moral imbeciles," one of psychopathic exaltation, and one of psychopathic depression.

In the group of constitutional inferiority were placed individuals with a moderate degree of intellectual inferiority and who showed serious defects emotionally. Most had long histories of repeated offenses. Three cases of sodomy, one of theft and one of assault occurred in this group.

Of those 50 cases under the heading "no psychiatric condition," 16 have temperamental difficulties, which make them unfit for service, but there is not enough evidence of any disorder to place them in any other group. The men of this group in 20 per cent of the cases assign alcohol as the cause for their commitment to prison; 14 per cent, a "bad gang"; and 10 per cent, "women."

In conclusion Doctor Jacoby writes: "The real value to the service of the expenditure of energy in ascertaining the mental state of its prisoners lies chiefly in directing us to a method of saving what is otherwise an economic loss. In this series of 150 cases, 81, or 54 per cent, are men who clearly should have been eliminated at the recruiting or training station; 19, or 12 per cent, developed a mental disorder after enlistment. For the reduction of the prison population by one half, then, a reasonably careful psychiatric examination at the beginning of the man's career in the navy is necessary. This examination need not be directed toward an exact diagnosis, but it should be in the hands of men trained in dispensary psychiatric work. Only a few minutes per man is required to detect the vast majority of this class, probably 80 per cent of them.

"For the elimination of the 12.6 per cent which develop abnormalities of mind in the service a psychiatric examination should be made of every man awaiting trial by general court-martial before his trial. If he is found abnormal, he should be discharged from the service or sent to a psychopathic hospital, depending upon the result of the examination. It may be said that such a practice might act contrary to the deterrent principle of punishment as a part of military discipline; but surely the harm done in committing an insane man to prison far outweighs any objection on that score. Such examination may, at times, be impossible because of the location of the trial, but whenever possible it should be done. As a most valuable aid in this connection a note should be made in the health record of any man when he shows any peculiarity of conduct, no matter how trivial it may seem at the time. A note made in one health record aboard ship described peculiar conduct, then of very slight importance, but suggestive of a beginning psychosis. Four months later the man was tried at a navy yard and sentenced to the prison, where, upon arrival, he is a well-developed case of dementia praecox. The most superficial examination before the trial might easily have convinced any medical officer of the existing psychosis, particularly with the aid of the previous note.

"There should be at the prison an adequate psychopathic ward for the observation of suspects, and every man admitted should be examined neurologically and psychiatrically, as well as physically. Here the work should be done most thoroughly in order to eliminate possible malingering. Cases, abnormal when enlisted and hopeless so far as usefulness to the service is concerned, should be discharged as soon as possible, consistent with work of a character which reduces errors of diagnosis to a minimum; provided, of course, that they are not likely to become public charges. Those of this class, which require public care, should be sent to hospitals in the state from which they come. Psychoses developing in the prison should receive hospital care, and to the very small proportion in which the psychosis is of such a nature as probably to destroy the social usefulness of the individual after his sentence has expired there should be given a discharge before this usefulness is too greatly impaired.

"In time of war, when all forms of energy must be conserved to the utmost, it is most highly desirable to eradicate expensive, nonproducing elements of the service personnel. It is a common observation aboard ship that this element forms roughly about 20 per cent of the ship's company. They are the men constantly on report and it is practically the same group which is always at sick call. The remainder of the men are striving hard and earning their full pay every day. The undesirable portion tends to gravitate toward the prison or hospital, where they are a further expense. Much is possible to be done toward the reduction of that expense by the elimination of them as soon as possible in their naval careers."

A STATISTICAL STUDY OF 164 PATIENTS WITH DRUG PSYCHOSES. By HORATIO M. POLLOCK, PH.D. *State Hospital Quarterly*, 4: 40–51, November 1918.

This study deals with 164 first admissions with definite drug psychoses admitted to the 13 civil state hospitals of New York, in the period of eight years from October 1, 1909 to June 30, 1917. The number of these cases constitute only a small part of the total number of drug addicts in the state, physicians having reported to the State Health Department 9,452 cases of drug addicts in the nine months ending April 1, 1918.

In the group studied there were 80 males and 84 females, but there is considerable variation in the number of each sex admitted from year to year—for instance in 1911 there were 13 males and 8 females. The total admissions varied very little in the years 1910–13; there was a marked increase in 1914 followed by a sharp decline in the succeeding years.

Drug cases constitute only a small part of the total first admissions to the civil state hospitals. In the eight years studied there were 47,316 total admissions, of which only 164 or 0.35 per cent were drug cases. In 1917 the percentage dropped to 0.12 per cent.

Forty-three of the 84 female cases were between 35 and 50 years of age when admitted; the age distribution of the male cases was irregular but all but 9 were under 60 years; 15 of the 80 males and 11 of the 84 females were either mentally deficient or temperamentally abnormal. Half of the 164 cases showed no physical disease; of the remaining half, 68 suffered from one or more physical disorders and 14 were undiagnosed. There was general disease in 16 cases and diseases of the circulatory system in 26 cases—organic disease of the heart and arteriosclerosis were the most frequent conditions found.

Of the 164 cases, 42 were single; 82 married; 23 widowed; 3, divorced, and 14 separated—the number of separations being relatively larger than among first admissions in most of the other groups of psychoses.

The data concerning family history were necessarily incomplete as full information could not be obtained, but the following facts were given with respect to mental disease, nervous diseases and alcoholism in the relatives of the drug cases studied:

Out of 143 cases reported with respect to insanity, 33 had insane relatives; of these, 6 had insane fathers; 6, insane mothers; 7, insane brothers or sisters; and 12, insane uncles, aunts or cousins. Only 21 of the 143 cases investigated had a family history of nervous diseases. A family history of alcoholism was found in 37 cases. The father was reported as intemperate in 31 cases, or 23.3 per cent. A study of family history with respect to alcoholism of all first admissions in 1913 showed 17 per cent as having intemperate fathers; a study of the first admissions of 1910, 1911 and 1912 with alcoholic psychoses, showed 31.9 per cent of intemperate fathers. It therefore appears that there is less alcoholism among fathers of drug cases than among fathers of alcoholic cases, and still less among the fathers of patients with other psychoses.

Only 4 of the 160 ascertained cases were illiterate; 18 could read and write; 104 had a common school education; 19 had attended high school and 15 had attended a college or university. The literacy of these cases was far ahead of that of first admissions taken as a whole.

Forty-two of the 164 came from rural districts and 122 from urban districts—or 25.6 and 74.4 per cent respectively. The corresponding percentages of the environment of the general population of the state in 1910 was 21.2 and 78.8—the rate of drug insanity being slightly higher in rural districts than in cities.

The study of even this small number of patients in regard to occupation reveals some striking facts; there were 8 farmers, 4 machinists, 4 painters, 5 physicians, 4 retail dealers, 5 salesmen, 5 laborers. From these seven occupations came 35 of the 80 patients; computed on the basis of 100,000 persons employed in respective occupations in the state in 1910, the highest rate was among physicians, 33.4; the next highest was among painters, 7.2; and the lowest was among laborers, 1.6 per cent.

Of the 84 female patients, 37 were wives with no gainful occupation; 4 were trained nurses; 9 servants; 3 dressmakers; 2 prostitutes; 20 were engaged in other occupations and 9 were unemployed. Computed on the basis of 100,000 persons employed in these respective occupations in the state in 1910, the hightest rate was among trained nurses, 31.0.

With respect to nativity, 139 of the 163 ascertained cases were native and 24 were foreign born. The percentages were 85.3 and 14.7 respectively. The corresponding percentages of the general population of the state in 1910 were 69.8 and 30.2. The rate of drug insanity is therefore higher among the native than among the foreign-born population. (One fourth of the foreign born came from Canada.)

Of the 164 drug cases, 158 were white, 4 were black and 2, yellow. The black and yellow, on a basis of the population of the state in 1910, represented a disproportionate number of the total.

As to the drug used, the extent of the use of alcohol in connection with each kind of drug used and the outcome of the cases in the hospital, the following facts were ascertained: morphine or opium in one form or another was used by all but 22 of the patients; cocaine alone was used by 8; and bromides alone by 5; tobacco and cigarettes were responsible for 3 cases; alcohol was used intemperately with the drugs by 71, or 43.3 per cent.

Recoveries were reported in 115 or 70.1 per cent of cases; 18 additional cases were discharged as improved, and 13 cases died. Of the 115 discharged as cured, 3 were in the hospital less than one month; 45, from 1 to 3 months; 43, from 4 to 7 months; 22, from 8 to 12 months; and 2, more than one year. The period of treatment in the hospital does not seem to be affected by any particular drug or combination of drugs, although the numbers in the several groups are too small to form a basis for positive conclusions. The course of the disorder varies but little in the two sexes.

Of the 13 patients who died in the hospitals, 5 were under treatment less than one month; 3, from 1 to 3 months; 1, from 4 to 7 months; and 4, 1 to 5 years.

In regard to the movement of the drug cases during the eight fiscal years, it was found that 132 of the 164 patients were discharged and 9 patients died within one year from date of admission; 5 of the discharged patients were readmitted within the year; during the second year, 12 cases were discharged, 1 died and 4 were readmitted; during the third year, 1 died and 3 were readmitted; during the fourth year 1 was discharged, 1 died; during the fifth year 1 was discharged, 1 died and 1 was readmitted. Altogether there were 146 discharges, 13 deaths, and 13 readmissions during the period. At the close of the period 18 of the 164 original cases were still in the hospitals—but the five-year period was complete only for cases admitted prior to 1913.

Conclusions: Only a small part of the total number of drug addicts develop psychoses; the two sexes are nearly equally represented in the cases with drug psychoses in the civil state hospitals; the patients with drug psychoses constitute but 0.35 per cent of the first admissions to the civil state hospitals during the fiscal years 1909–1917; drug cases are admitted principally during the middle life period; half of the cases are free from physical disease at admission—among the other half, circulatory diseases are most common; alcoholism is prominent in the father in the family history of the drug cases; drug cases rank high in regard to literacy; the rate of drug cases is higher among the native than among the foreign born; opium and its derivatives were the principal drugs used and approximately 43 per cent of the patients also used alcohol intemperately; about 70 per cent of cases recover within one year from admission, the kind of drug not affecting the length of treatment; five and one half per cent of the cases with drug psychoses die within one year from admission; approximately nine per cent of the cases discharged are readmitted.

MENTAL DEFECTIVES AND THE LAW. BY FRANCIS D. GALLATIN. Published by the New York Committee on Feeblemindedness and the Committee on Mental Hygiene of the State Charities Aid Association. 20 p.

The need of reform in current legal procedure for dealing with defective delinquents is pointed out in this article based on a study made in the preparation of a report to the Committee of Criminal Courts and Procedure of the New York County Lawyers' Association, of which committee the author is Chairman. He emphasizes the fact that "the law is in need of amendment, and steps should be taken toward recognizing in criminal matters the mitigated responsibility of the defective," and suggests that the law be changed so as to take into account, that while such individuals may be adults in years, mentally they are children and should be dealt with in a different manner from normal offenders.

The writer believes that the war is certain to result in an increase in crime that will render even more imperative than ever improved machinery for dealing with defective offenders. He finds evidence that "from a quarter to a third of all delinquents are defective," and that the bulk of the crimes by defectives are committed by those of the higher grades, or morons, who are now held legally accountable for their acts and can only be sent to prison for definite terms. The result of this procedure is shown by psychiatric reports to which the author refers, and is also reflected in the large proportion of recidivism.

"These unfortunates are unable to adapt themselves to their surroundings and easily fall into the ways of crime. . . . Punishment has no effect. Training and protection only can be of service. . . . On the expiration of their prison terms they are turned back into society free to reproduce themselves and to continue their antisocial careers."

The author advocates the establishment of psychopathic clinics in connection with courts and penal institutions, and the enactment of legislation for the segregation and detention or proper supervision of defective delinquents, pointing out the advantage that would accrue to the state from the early detection of their feeblemindedness and the subsequent segregation and training. He writes: "The advantage that would redound to the state from the early detection of these individuals and their subsequent special treatment cannot be exaggerated. The senseless round of their arrest, conviction, imprisonment and liberation would cease; they would be kept under supervision or else permanently removed from the community and placed in institutions where the security of the prison would be combined with educational methods. There is no doubt but that such action, if safeguarded by periodic and careful examination, would work no injustice, and would greatly diminish crime."

Legislation is briefly presented on the subject of sterilization, and citations made to show this to be an inadequate method of attacking the problem.

The British Mental Deficiency Act, considered a model of its kind, and acts recently enacted in Massachusetts and Illinois are mentioned as offering suggestions for legal procedure in relation to feebleminded offenders. The author observes that a law was passed at the 1918 session of the New York Legislature allowing magistrates to place women convicted of a certain category of offenses under observation as to their mental and physical condition. This he pronounces "a step in the right direction." In general, however, he says: "The law of the State of New York has not as yet recognized the diminished responsibility of the defective in offenses against its majesty. An individual in its eyes is either responsible or he is not, and it lays down a strict rule for the testing of this responsibility." He formulates this new viewpoint:

"The only test of criminal responsibility recognized by law is whether the defendant knew the nature of the act of which he is accused and if so, whether he knew it to be wrong. If he so knew, he is to be held responsible, abnormal as he may otherwise be. . . .

"The law in its attribution of criminal responsibility makes no distinction between the normal individual and the mental defective. Certain low-grade mental defectives, it is true, being ignorant of the nature of their acts or incapable of realizing their wrongfulness, are declared irresponsible by the courts and dealt with in a manner appropriate to their condition. These are the exception and not the rule.

"With the high-grade mental defective this, under the present law, is not possible. He knows the nature of his act and that it is wrong. To him is attributed criminal responsibility to the same extent as to the mentally sound. No weight is given to the fact that in mentality he is but a child.

"Yet toward the child in years the law assumes a paternal attitude. Up to the ages of sixteen, it deems his wrongful acts, with the exception of murder, not crimes, but juvenile delinquencies and deals with the delinquents themselves on lines not penal, but reformative and educative. They are not punished but cared for and instructed. They are not viewed as criminals, but unfortunates over whom the state, for their own good, extends its protecting arms. This exceptional treatment is accorded not on account of their youthful age as such, but on account of the undeveloped mentality which accompanies it. Why should it not also be accorded to those unfortunate individuals chronologically adults but in mentality and adaptability to their surroundings, children? The answer seems obvious."

Mr. Gallatin does not anticipate that if defective criminals were dealt with in a different manner from normal offenders there would be a tendency for persons to seek immunity from punishment by claiming to be mentally defective. The situation, he says, would be just the reverse of what exists with the insane, whereby persons charged with serious crimes often seek to escape conviction on a plea of insanity. The feebleminded, on the other hand, the great majority of whom commit only misdemeanors, would prefer a short term in prison to possible lifelong supervision in an institution. On this point Mr. Gallatin says:

"It must not be thought that if the law should admit the mitigated responsibility of the mental defective that the plea of mental deficiency would be used in attempts to defeat justice, as is now the plea of insanity. Similar scandals could not follow. In fact, as a practical matter if such legislation were enacted, the court would be met with the converse of the proposition now usual where insanity is pleaded.

"When the latter plea is interposed, it is generally by way of avoidance, with the hope that by proving mental derangement the defendant may escape heavy punishment, usually death in the electric chair. Counsel for the defense strains every nerve to prove the unbalanced state of his client's mind. A verdict of insanity is viewed in the light of a victory. On the other hand, the District Attorney strives to demonstrate the sanity of the defendant.

"Far different the circumstances of the trial of a feebleminded person. As a rule the offense charged would be of a comparatively minor nature and a short term of imprisonment the extreme punishment. It would be to the interest of the state that an unsocial individual who would probably remain so permanently, should be placed where he could no longer be a menace. The defendant, on the other hand, would prefer a definite term in prison to confinement in a custodial institution for mental defectives, possibly for life. Accordingly the proof of the existence of mental deficiency would fall on the prosecuting officer; that of mental soundness on the defendant's counsel. The situation usual in the trial of insanity pleas would be reversed.

"Not all defectives commit crimes, but all are liable, given an unfavorable environment, to display antisocial failings. Detention or supervision only can prevent the fructifying of weakness and its conversion into actual wrongdoing.

"The treatment and custody of defectives who have given expression to their criminal tendencies presents a serious question. With many, a system of probation and careful supervision would be sufficient, with others confinement in custodial institutions would be necessary. It is above all important that the defective be segregated. . . .

"To avoid the large expense incident to the construction of special buildings for the segregated care of defective delinquents, it has been suggested that they be confined in one of the existing institutions which could at no large cost be adapted and set apart to this purpose. In this manner a simple redistribution of the population of our prisons and reformatories would at small cost attain the desired result.

"It is evident that penal or reformatory treatment is not adapted to the defective. His requirements are distinct from those of the normal delinquent. With special treatment much can be done to improve the situation of these inferiorly constituted social units.

"Although in mentality children, defectives are frequently physically sound and capable of leading useful lives when supervised and trained. . . .

"The state owes to these, its most helpless citizens, care and protection, and to itself that they should cease to be elements of disorder. Both of these aims are possible of realization."

IN DEFENSE OF WORRY. Editorial in *The Outlook*, 120: 656–57, December 25, 1918.

"In view of the unjust disrepute of anxiety as a form of mental exercise, an examination of the many good reasons why we should worry is sharply pertinent.

"The best argument for worry is the kind of people who tell you not to. Their smooth foreheads are likely to suggest a corresponding internal blankness. It seems as if even to themselves they must be savorless, these never-worriers. As to achievement, they can never reach the highest; they may jog complacently either on a mediocre level of success or may, like Mr. Micawber, dance nimbly along the surface of flat failure, but to attain the sure foot that scales the heights one must possess a vivid sense of pitfalls. Poor dullards of optimism, they miss the zest of that success granted only to those who have worried out a course of conduct to meet the most pessimistic forecast of the future.

"As a friend the confirmed optimist is monotonous. You like a few ups and downs in a friend. The never-worrier offers the resilience of a punching-bag to the blows dealt him by his own life, and a corresponding indifference to the blows dealt him by yours. In order to worry well over some one else one has to be thoroughly practiced in worrying over one's self. We all know that when we want sympathy we turn to the best worrier we can find, knowing that he will take our case right on and have a fit over it. When we are choosing a comrade, we find the fact that a person has denied himself the enriching luxuries of worry a positive deterrent.

"Another argument for worry is the kind of books that tell you not to. Apart from their character, their very popularity furnishes cause for profound regret that people desire to buy even joy at wholesale, that they may demand even cheerfulness in the terrible tins of the ready-made. Such cheerfulness is sadly attenuated by the absence of good, meaty truth. The only cheer that contains nutriment is the kind that you raise in your own garden and put up with your own hands. A work that can announce itself to the dry-goods counter as "The Happy Book" is a book promptly shunned by readers who read. Such a book is as true to life as a child's book of sketches—shapes whose conventional outlines make them pass for men and women and wheelbarrows, daubed in colors of unshaded radiance.

"The manufacturers of the happy book and the happy ending are unhampered by such bagatelles as life and truth and art, and thus perhaps their nursery pinks and blues may bring joy to all but two perverse classes, the writers who yearn to portray life, the readers who yearn to have it portrayed. These two classes belong, however, to the still larger one of worriers-by-conviction. They remember, perhaps, a certain passage of inimitable anguish over the casting of a little silver image. Why should Cellini have worried over his Perseus? Merely because he was Cellini and an artist. They remember the sweatings and the blood-lettings with which certain books have come forth—books not happy, perhaps, but for all eternity great, because by painting truth they clear our eyes and strengthen our wills to manufacture our own happiness.

"The worriers-by-conviction know that in no department of life is the maxim that conscience makes cowards of us all so true as in the aesthetic. Fear is the beginning of imagination, and the only kind possible to dull minds. It follows that fear is the first step in the evolution of appreciation, which finds its flower in the creative temperament. All along the advance, pessimism, pointing out the shadows, prying into the pitfalls, sharpens the sense for values of which true art must be composed. The imagination that is able to visualize any success worth achieving must necessarily be able to visualize failure and to quiver beneath the lash of its possibility. The artist who does not worry had better instantly spur himself to worry over that fact, for worry is a fundamental intellectual asset.

"The moral advantage of fever and fret are even greater than the mental. Our ancestors recognized this fact and provided for it, but our pusillanimous cheerfulness recoils before their robust recognition of muscle. Knowing the placidity resultant from being unable to stand up and fight a good husky Fear on his own ground, they created the Fear and the ground, calling the one the Devil and the other Hell. There used to be a most stimulating little signboard at the entrance of hell, 'Who enters here leaves hope behind,' but many moderns make the depressing amendment, 'There isn't any such "here" to enter.' In like manner unconsciously, we pine for the good old devil of our forefathers. He used to be always hanging around handy for you to test your heroism upon him. He was worry incarnate, providing the most muscular exercise for anybody who wanted to wrestle. The anti-worry campaign denies the usefulness of bugaboos, whereas a really good bugaboo is a liberal education. Constant companionship with him is a training in imagination, in sympathy, in self-dependence, and, last—an argument which knocks out from under him the strongest support of the optimist —in the joy of life.

"Can the non-worrier ever know the hero thrill of the hair-breadth rescues we did not make when the boat did not go down? Can he experience the pride of the economy we did not practice when the bank did not fail? Has he ever tested the quintessence of relief when the best-loved one did not die of the pneumonia she did not have? How can the poor optimist ever discover that one actually runs faster towards one's desire when the dogs of worry are nipping one's heels? Never the goal so alluring, never the pace so fleet, never the tingle of achievement so keen, as when one perceives the prize threatened. What does he know about success, the man who has never feared that he might fail? What does he know about happiness, anyway, the man who believes in being happy all the time? The truth is that worry puts a gilt edge of joy on everything.

"But worry, to be genuinely educative, should be systematic and not slipshod. The worrier should have convictions to meet those of the good-cheer propagandist. But in this effort after analysis and argument your worrier must be mindful of one danger. Method with melancholy inclines to have the same result as the proverbial tear-bottle offered to the crying child. In other words, worry is an elusive visitor; welcomed and analyzed, she is as likely as not to go flying out of the window."

BOOK REVIEWS

MEDICAL AND SURGICAL THERAPY: VOLUME 2: NEUROSES. Edited by Sir Alfred Keogh. New York: D. Appleton & Company, 1918. 933 p.

In this volume are brought together in translation four important French works on nervous disorders of frequent occurrence in war time. The first two sections are by Madame Athanassio Bénisty and are on *Clinical Forms of Lesions of Nerves*, and on *Treatment and Repair of Nerve Lesions*, respectively. The detailed manifestations of the lesions of the individual nerves are described very clearly; methods of examination are given and the whole article is well illustrated by anatomical drawings and by drawings of the special postures consequent to the lesions of the individual nerves. The treatment and repair of nerve lesions is discussed in a very practical way. The authors recognize how difficult it is to formulate definite and regular rules with regard to operations on nerves. "Nothing would be less scientific or more risky in the present state of our knowledge than to lay down definite axioms, always a dangerous thing in clinical medicine. . . . The chief concern of the surgeon should be to respect the continuity of the nerve, not to form resections too hastily, and always to bear in mind the delicacy of nerve tissue, and the difficulty of its repair. . . . There is no justification for regarding as incurable, nerve lesions more than a year old which have been operated on properly, even if they do not yet show definite signs of regeneration. Time may bring about unexpected cures. *Therefore when a medical board has to make a decision*, a certain caution should be exercised in prognosis" (p. 308).

A special chapter is devoted to the physio-therapeutic treatment of injuries to nerves, and among these, prosthetic appliances are discussed in detail.

The third section is entitled *Hysteria or Pithiatism*, by J. Babinski and J. Froment. In the first half of this section the authors give an historical review of the question of hysteria and formulate the point of view which Babinski has brought forward so clearly in a long series of communications, and which he succeeded in more or less establishing after the classical discussion on hysteria before the Société de Neurologie, of Paris, in April and May 1908. The historical matter in this section is followed by a general discussion of the symptomatology of hysteria with regard to which Babinski's views are now familiar. He lays great emphasis on the rôle of suggestion, and would eliminate the swarm of vasomotor and trophic disorders which have been grafted on the clinical picture of hysteria.

In the second half of this section the authors discuss "reflex nervous disorders." These are motor disorders which are not accompanied by the usual signs characteristic of typical organic affections but resemble in some features hysterical manifestations. They are distinguished by the fact that, in addition to such symptoms as contracture and paralysis, one is liable to find muscular atrophy, alterations of the deep and cutaneous reflexes, change in electrical reactions, sensory disturbances, secretory, trophic and vasomotor disorders. These phenomena have also been entitled "physiopathic," and their origin is somewhat obscure. The authors discuss in separate chapters the symptomatology and pathogeny and the diagnosis of these disorders. The article is followed by a considerable bibliography.

In section four, J. Roussy and J. Lhermitte discuss the psychoneuroses of war. The first chapter is devoted to the familiar hysterical paralyses, hemiplegic, monoplegic and paraplegic. In the second chapter, psycho-neuropathic disturbances of gait are discussed, and in the following chapters involuntary movements, sensory disorders and disorders of the special senses and visceral disorders are discussed. A special chapter is devoted to nervous attacks such as fits of terror and fits of motor agitation. Psychical disorders are taken up in Chapter IX.

With regard to the treatment of the psychoneuroses of war, the authors emphasize the importance of correct environment and of the personality of the physician. Hypnotic suggestion ought definitely to be rejected as a method of treatment, according to them. Persuasive conversation and the use of faradism are the main elements in the treatment, and they are reinforced by isolation with a rather thin diet as a stimulus to recovery.

C. Macfie Campbell.

The Philosophy of Conduct; an Outline of Ethical Principles. By S. A. Martin. Boston: Richard G. Badger, 1916. 238 p.

Little as we may find to our purpose therein, it is the duty of mental hygienists to glean every new work on ethics for the slightest hint of an awakening by moralists to the point of view of psychiatry. Some of the moralists, of course, awake with a start to find themselves—Freudian! From these lightning-change moralists, we, as good mental hygienists, doubtless learn nothing that we do not already know. But Professor Martin is not of the sudden converts and in fact renders an account at first sight rather old-fashioned—"the distinction between Christian ethics and philosophic ethics rests on a misconception of the truth."

But there are signs in the book of many strong modern influences, shaped during twenty years' teaching—Martin is Professor of Philosophy at Lafayette College. I note the name of William James on the first page and *passim*. Almost half the book is devoted to personal ethics—a welcome reaction to the dominance of group ethics in most modern expositions. Again, "ethics should be treated as a natural science." Martin counsels the use of Green's *Prolegomena* and Seth's *Principles of Ethics* as supplementary reading. He declares especial debts to Seth, *re* metaphysical implications of ethics.

This is no place for a thorough review of this book from the ethical or philosophical point of view. I call attention merely to a few points of interest to mental hygienists. The chapter on *Moral Pathology* takes a point of view opposed to that of Rousseau, who thought civilization made men bad, and is aligned rather with the ingrained pessimism of, for example, Freud. Martin states that "we do not begin life with an unbiased mind, but with a soul corrupted by hereditary taints of evil. The mistakes and faults and evil choices of innumerable ancestors formed habits, defects and disordered states which have become constitutional in our race. . . . The moral depravity of the race is the sad inheritance of every child born into the world. . . . 'Total depravity' " means that "the whole race is morally unsound, and this unsoundness affects every faculty and function of the soul. And this indictment is certainly proved by history and observation and experience."

The result of this is naturally that "ethical culture is first of all a matter of pathology—a work of healing a disordered condition of the soul." I have recently written an extended commentary on Freud's *War and Death*, pointing out this selfsame fundamental pessimism therein which crops out in Martin's chapter on *Moral Pathology*. I myself believe we should make head against this one-sided view of the evolutionary situation. Did not someone quote from Dickens that, while the sins of the fathers were being visited for X generations on the children, at the same time the virtues of the *mothers* were being visited also? I should not be feminist enough to divide up the vices and virtues quite so cleanly.

In the meantime Martin is really not a pessimist of the deepest dye like the real exponents of total depravity. Martin is really a good deal of a meliorist (see his chapter on the *Culture of Virtue*) and insists on the value of casuistry—"a most respectable science unfortunately handicapped by a bad reputation." By the way, reference is made on page 225 to some examples at the end of the book for practice and discussion—but these examples seem to have been omitted. The late Professor Royce made considerable use of this casuistic method in his university extension courses in ethics, and Dr. G. C. Cox has written in favor of a more extended use of ethical "cases."

On the whole this book seems a hopeful sign of the digestion by philosophers of modern behaviorism and instinct-psychology; it is to be commended for its advocacy of the casuistic method and for its emphasis upon personal ethics; and incidentally it is well supplied with a variety of interesting quotations and statements from moralists and poets.

E. E. Southard.

PRACTICAL MEDICINE SERIES: VOLUME 10: NERVOUS AND MENTAL DISEASES. Edited by Hugh T. Patrick and Lewis J. Pollock. Chicago: Chicago Yearbook Publishing Company, 1918. 223 p.

This publication is one of a series of ten volumes on the year's progress in medicine and surgery and consists of abstracts of American and foreign literature on nervous and mental diseases, with an occasional editorial comment. Under the heading, *Diseases of the Nervous System*, the larger part of the book (183 pages) deals with the literature on such topics as the neuroses, cerebral spinal fluid, diseases of the brain including war injuries, and diseases of the spinal cord and peripheral nerves. Under the division of *Psychiatry* attention is called to articles on general topics, the field of mental hygiene being represented by two articles by Friedman and Salmon. In addition, publications referring to mental defect and delinquency, insanity in the war, dementia praecox and manic-depressive insanity, and senile dementia are reviewed. In a single volume it would be of course impossible to review at all completely the voluminous literature of the year on the many subjects touched upon, and there might be a difference of opinion regarding the choice of the articles indicating the most progress. It would seem, however, in general, that a wise selection has been made. The abstracts are believed to be well done, and on the whole the book is considered to have a distinct value as an aid to keeping readily in touch with at least a portion of the literature on a wide variety of topics.

CLARENCE O. CHENEY.

THE THIRD AND FOURTH GENERATION; AN INTRODUCTION TO HEREDITY. By Elliot Rowland Downing. Chicago: University of Chicago Press, 1918. 164 p.

This small book is intended to be one of "a series of graded textbooks representing biblical and ethical subjects, arranged to cover all grades from the kindergarten to adult grades." It constitutes, thus, an interesting attempt to present the facts of human inheritance and reproduction to persons in Sunday School Bible classes, to ministers, and to "laymen, who are desirous of obtaining in untechnical language an idea of the problem of evolution." This attempt is interesting because it has been made by a well-trained man of science and the data he presents have been critically selected and set forth with the technique of a highly successful teacher of teachers. The book begins with an account of famous American trotters and their pedigrees, setting forth the notorious facts of origin from a single great ancestor "Messenger," who was, doubtless, a mutation. The case of a family of famous Jersey dairy cattle is likewise cited and thus the way is paved for a consideration of the Darwin-Wedgewood-Galton family, of the Bach family of musicians, of the Jukes and the Edwards families. Having thus presented the reader with a body of fact concerning family traits, the author describes the method of sexual reproduction in flowers, birds and frogs so as to make clear the nature of biparental inheritance. In a further chapter the Mendelian laws of heredity are set forth in simple form. Next, their application in the improvement of domesticated plants and animals. Then the facts of chromosomes as bearers of the determiners of inheritable qualities are described and finally some of the complications of the simple Mendelian formulae. In a single chapter the question of the inheritance of acquired modifications is considered. Then the method of inheritance of particular traits, such as cataract, short fingers, feeblemindedness and insanity are discussed and finally reference is made to the importance of eugenical principles for the improvement of the human race. The book may be cordially recommended as a brief, clear and safe guide to the elementary facts of human heredity.

CHARLES B. DAVENPORT.

THE UNMARRIED MOTHER. By Percy G. Kammerer. Boston; Little, Brown & Company, 1918. 342 p. (Criminal Science Monograph 3.)

The social pessimist who doubts all progress ought to take to heart the significance of this book. It is a discussion of the problem of illegitimacy based upon an inductive study of five hundred case histories, chosen from a large collection of life records, for the purpose of discovering the causative factors in the pregnancy of an unmarried woman. Sixty-nine cases are reported in the book after the manner of William Healy. The book is written "in the belief that enlightened public opinion may in time see fit to modify the community attitude towards the unmarried mother and her child." Healy has contributed a brief but valuable introduction.

The causes of illegitimacy are treated under the following chapter headings: *Bad Environment, Bad Companions, Recreational Disadvantages, Educational Disadvantages, Bad Home Conditions, Early Sex Experience, Heredity, Abnormal Physical Condition, Sexual Suggestibility, Abnormal Sexualism, Mental Conflict, Assault, Incest and Rape,* and *Mental Abnormality.*

The author insists that illegitimacy is "but another instance of social maladaptation," a problem that must find its solution in a better social treatment of the individual. He presents the following program for a more socialized and scientific effort to solve the problem of illegitimacy:

1. Steps should be taken for the control or segregation of the mentally abnormal woman during child-bearing age.

2. An attempt should be made to enact laws that will reflect the European experience in regard to the unmarried mother. The chief aim of such laws should be the welfare of the child.

3. There should be an extension of effort toward social betterment through improved home conditions, greater cooperation between parents and their daughters, and more emphasis upon the social value of recreation.

4. There should be a different attitude on the part of the public toward matters of sex. "No longer can one feel that so important a factor as the sex instinct can be left out of consideration in the education of the growing girl."

The book leaves the reader with a clearer realization of the responsibility of society itself for the unmarried mother and with the regret that so persuasive and illuminating a treatment of a great social burden is not likely to be read by those who need most to feel its influence. No social worker, however, is likely to be in the group of the static minded, and the circulation of this volume among those who most often deal at first hand with unmarried mothers fortunately will be as great as the author can desire. The book contains social momentum and will surely make some impression upon even the hard-crusted custom of backward-facing ignorance.

ERNEST R. GROVES.

THE MENTAL SURVEY. By Rudolf Pintner. New York: D. Appleton and Company, 1918. 116 p.

This little book is an exposition of the use of six intelligence tests given to school children in groups. These tests are a rote memory test, in which words are spoken, and written down after a group has been called; the digit-symbol test; the symbol-digit test; the word-building test, in which as many words as possible are written, made of the letters A, E, I, R, L, P; an opposites test; and a cancellation of "as" test. The first five of these tests have been used by Pyle and others. Normal performances obtained by the author are compared throughout with those secured by Pyle and others. The author tested by means of these six tests nearly three thousand children in four city schools, one village school and four rural schools. He gives simple and precise directions for the administration of the tests, for scoring and for making percentile ratings. The percentile rating is given for each one of the six scores made by each child. This makes a large amount of work which can be of use only in further splitting up or modifying the series of tests used. The rating of the individual child could just as well be given for these six tests by a summed up score which would assume its place in the percentile series for his age.

One of the great functions to be performed by such group intelligence tests, as the author sees it, and as we must all agree, consists in the comparison which is thus made possible between native endowment, of grades and schools, and educational progress. The author develops this point and illustrates it at considerable length, using Trabue's completion test and Courtis' arithmetic test as examples of educational tests. By this means he shows that while one grade of school may be lower in intelligence endowment than another, it may at the same time be doing better work in English or in arithmetic than should be expected of it, while a better school may be doing poorer work than should be expected of it, and yet the first-mentioned school is doing absolutely poorer work. The teacher of such a school may readily be reaping the discredit for poor work. These or other intelligence tests might demonstrate both superior and inferior teaching ability where they were not suspected to exist.

While the author is duly cautious as to the possible inaccuracies of these group tests of intelligence, he has been very ingenious in developing their utility and showing how they may be used as an indispensable aid in educational surveys in checking up the school work from the point of view of native endowment of pupils.

The group tests the author suggests will likewise be of value in estimating feeblemindedness and in all social surveys. These objects are largely identical. Intelligence ratings as used in social surveys are for the same purpose as in the army and in industry, that is to eliminate the feebleminded and to sort out human beings according to their capacity and fitness for service. These ratings can be well made from results obtained from group tests.

Dr. Pintner uses the median score and the percentile distribution of scores throughout as a means of standardization. The observation of the gradual stabilizing of successive groups of scores is a useful criterion of the validity of norms. If the worker is careful to get, by empirical means, a wide variety of the processes tested, then when the median remains stable through successive increments, a norm has been attained.

Correlations are exhibited between some scores made on these tests, on the one hand, and (1) teachers' ratings, (2) Yerkes scale scores, and (3) Binet scale scores.

It would be very desirable to have in a series of group tests designed for the purpose in question a greater variety of mental functions called into operation. In this connection it is to be noted that a shorter time than five minutes will abundantly show the capacity of a child to deal with such an operation as that involved in the symbol-digit test. Two minutes on this test would be of as much service as five minutes. Ten two-minute tests distributed over a wider field of mental adaptability would reveal more and be less fatiguing than these six tests of five minutes each.

The author speaks of the inaccuracy of results in the rote memory tests. For instance, this may have resulted from writing down the words while the words were being spoken. This difficulty could easily be avoided by selecting a test in which the material was on the paper.

It would be desirable to have the test sheets bound together. This would save not only the time of distribution, but the time of assembling.

One who has had as many as six different sheets from each of forty children who could not write their names very plainly knows the time it takes to assemble these records. Against this, the separate sheet has this advantage in that the test possibly can be made so plain and simple that the teacher can give it properly. Also, if she has the tests on separate sheets she can give one test at a time whenever time offers. It is advisable, however, that the tests be made the subject of serious and consecutive consideration in a given room until they are carried through, and that the matter be in the hands of one thoroughly trained in giving the tests.

A great saving of time can be effected by the use of celluloid stencils. The tests can be so arranged that the time-consuming work of correcting such a test as the digit-symbol for example, can be very largely eliminated.

Although these tests were made prior to the work of the Committee on Methods of Examining Recruits in the Army, and that of the Division of Psychology in the Surgeon General's office, the book has been prepared and published since the methods of group testing in the army have been thoroughly established. Many of the points in group testing as used in the army show considerable improvement over the methods of the author. Testing the intelligence of school children in the future will undoubtedly be in large measure by the group method. But points of superiority which have already been developed make it improbable that the scale or tests set forth in this book will have any great part in that development. The methods here used in correlating results will have a great future. These are a distinct contribution to intelligence testing. It is the tests, themselves, and the scoring methods upon which improvements have already been made.

THOMAS H. HAINES.

DIE PSYCHOPATHISCHEN VERBRECHER. (The Psychopathic Criminal.) By Karl Birnbaum. Berlin: P. Langenscheidt, 1914.

The wide popularity and recognition which psychometric methods have attained in the study of mental equipment and capacity have served the very desirable purpose of drawing sufficient attention to mental deficiency among the socially maladjusted. But along with this popularization of these methods there crept in the danger of a too dogmatic belief in the various scales of intelligence measurement with the result that on the one hand cases have been placed in the defective group which did not properly belong there; and, what is still more important, cases of definitely pathological constitution have been entirely overlooked because the pathological in them could not be defined in terms of intelligence defect. This is particularly true of those conditions which psychiatrists are wont to designate as "psychopathic constitutions," "constitutionally inferior," "degenerative personalities."

Experience with the various psychometric methods soon demonstrated that while the psychopathic individual may be burdened in addition to his general inferiority with a defective intelligence, he need not be so burdened, and in fact shows no intellectual defect *per se* in a great many instances. In other words, the psychopath may not, and actually does not in many instances, demonstrate any such deviation from normality as might be defined by means of the various psychometric methods. Psychometry aims at the definition of mental processes and equipment which have to do primarily, if not solely, with the intellectual component of man, and ignores largely, if not wholly, his emotional and volitional components. Yet the sphere of the emotions constitutes the central point of all psychic life which it permeates in all its manifestations. It is the determinant of all important characteristics of behavior; it is of essential importance for all thinking, feeling and acting. It constitutes the root of personality: that which characterizes the essential nature of a given individual, his personal characteristics, is in closest relation with his emotional life. It is not only the individual's particular way of expressing his affects, his personal, religious, moral, esthetic and other feelings, but also his peculiar way of thinking and of exercising judgment, his fundamental viewpoints, principles and dogmas, his criteria and standards, his intellectual interests, all of this is determined to a pronounced degree by emotional influences.

The situation is no different when it comes to volition and action, to the carrying into execution or the abandoning of a given line of action. This, too, derives its starting point from the emotional sphere, and the relationship is obvious in such modes of behavior as clearly bear the stamp of the affective, instinctive and spontaneous. But even in clearly deliberative, voluntary activity, we may detect emotional factors at work. The motives for all indulgence or abstinence in behavior are derived from emotional tones (pleasurable or unpleasurable imagery, attraction and repulsion, strivings and counter-strivings). Upon the strength of these feelings depends the intensity of the motive, and by the same token, the urge for the action. In the battle of motives, the decision rests with the side which possesses the preponderance of affectivity.

In thus stressing the emotional component in the behavior of man, Birnbaum succeeds very well in preparing the reader for what is to follow in his discussion of what he terms a "psychology of psychopathy," to which the major part of the book is devoted.

For, if a thorough consideration of emotional factors is absolutely essential for the understanding of behavior in general, this is especially true for the understanding of the behavior of the psychopath, whose main distinguishing characteristic of constitution is a *pathological affectivity*. If one were to attempt at this juncture to define further the general concept of psychopathy one might find it convenient to draw a differentiating line between the psychopathic personality and the intellectually defective *per se*, or the feebleminded. Not that these conditions are at all mutually exclusive, but in dealing with clear types one finds on the one hand a state of general deficiency—an *oligophrenia*—as Kraepelin terms it, while on the other hand it concerns a partial deficiency, a stunted or perverted development of some one or more psychic attributes. While the feebleminded individual need not become antisocial, or a difficult individual social problem, or even markedly asocial, for many feebleminded have been known to lead serene, peaceful and fairly useful lives under properly adjusted conditions, no feebleminded individual is likely to distinguish himself by an act of exceptional social usefulness or productiveness. That this is not true of the psychopath, one might expect from a consideration of the essential nature of psychopathy and from a glimpse at the lives of many prominent historical personages who were undoubtedly psychopathic.

The psychopath contributes in no small degree to the problem of social maladjustment (among last year's admissions to Sing Sing at least eighteen per cent were so classified); but he is also capable of acts of unusual social value. It must be evident that this fundamental difference between the purely feebleminded and purely psychopathic carries with it a most important therapeutic bearing. The comparative simplicity and uniformity of the clinical picture of the "*oligophrenic*" may well find a therapeutic solution in the various types of custodial and pedagogic care, but no great therapeutic benefits can accrue to the psychopath from such comparatively simple and uniform methods. Each psychopath constitutes an individual problem in psychopathology, and requires for a proper understanding and administration, a much more intensive individualization. Birnbaum recognizes this fully when he warns us that a too isolated consideration of the individual traits of character of the psychopath (to a delineation and discussion of which he devotes over three hundred pages of his book) will not give us a clinical picture which corresponds with reality: that, after all, in actual practice one does not come in contact with individual traits but with personalities, in whom all sorts of imaginable combinations of pathological traits exist.

Because Birnbaum includes in his book a discussion of degenerative feeblemindedness (Verstandesmängel bei Psychopathen und degenativer Schwachsinn, p. 276) one must not conclude that he is not conscious of the differentiation which we have outlined above between pure feeblemindedness and psychopathy. We have already stated that the two conditions are not mutually exclusive. Feeblemindedness is frequently the result of that *degenerative anlage* which Birnbaum marshals as the chief etiologic factor of psychopathy and the soil upon which this condition develops.

It is readily understandable, therefore, how the feebleminded may be burdened in addition to the intelligence defect with psychopathic traits, and that the psychopath may show as part of the clinical picture, an underdeveloped intelligence. He believes, however, that good intelligence in connection with psychopathy comes to light in social life, by preference, in a salutory fashion. It enables the psychopath to neutralize his antisocial tendencies, or, at least, to check their expression from utilitarian motives. Good intelligence is, therefore, not to be sought in the criminal psychopath, although one finds it here often enough. Good intelligence not always succeeds in the face of the more potent emotional factors, as the contrast between good insight and intentions and the totally contradictory behavior demonstrates.

If therapeutic considerations demand a clear understanding of the difference between pure feeblemindedness and psychopathy, the necessity for this becomes still more urgent for diagnostic purposes. While objective and experimental psychology, upon which the various psychometric methods are based, serve to a remarkably dependable degree for the definition of pure intellectual deficiency, albeit only as a most important adjuvant factor in diagnosis, these objective psychological methods fail us almost entirely when we attempt to define the psychopath. Here one must have recourse primarily to a probing of the subjective life of the individual, and how terribly unconvincing our findings as result of such probing seem to the uninitiated. Yet it is the uninitiated, on the part of whom a clear recognition of the concept of psychopathy is, after all, most essential if the psychiatrists' contributions to social problems are to attain their full pragmatic value.

One might hold forth very learnedly, indeed, before many a judge and jury, anent the psychopath's general inconsistency, his emotional instability and impulsiveness, his tendency to paranoidism and peculiar valuations, his overweening egotism or abject dependency, his weakness of will and impressionability, his penchant for the phantastic and rumination in a life of unreality, his chronic irritability and intolerance which are bound to bring him in conflict with his environment, without in the least succeeding in attaining one's object of producing in the minds of these gentlemen a clear conception of the biologic background of a given antisocial act. Not because they are not willing to see the true facts in the case, but because what the physician has told them in these psychiatrically very significant terms means to them not much more than "hearsay" in legal phraseology. The physician cannot support his opinion by facts elicited from an *objective examination of the individual*, and his opinion never carries the same implication as does an opinion based upon the observation of what is considered to be insane behavior, or as that laconically expressed in the phrase that the individual possesses an intelligence of, say, eight years. That this extremely balking difficulty of diagnosis is inherent in the nature of psychopathy and not in diagnostic methods should not be an excuse for ignoring it. It would do far greater credit to the psychiatrist, and would tend in an infinitely greater measure to advance our knowledge of the subject, to face this diagnostic difficulty squarely and to admit the great need on the one hand of a clearer delineation of the traits of the psychopathic personality and of the development of more dependable methods for the objective elicitation and detection of such traits, and on the other hand, of a full recognition of the vital part which a painstaking and dependable research into the antecedents and past personal experiences of the psychopath plays in the diagnosis of his condition.

More precisely, there is needed a much greater utilization on the part of administrators of public institutions of thoroughgoing field investigations than has been the case heretofore. The first of these requirements is fulfilled in a very large measure by the book under discussion, which is a veritable encyclopedia of psychopathic traits and done with a hitherto unequaled thoroughness. As might have been expected, Birnbaum, too, fails to furnish us any royal road to diagnosis, such as might have answered the recent query of a group of prominent psychologists as to what psychological tests might diagnose the psychopath. But the marvelous system of public records in Germany, which one may detect in Birnbaum's case material, must in this country be replaced by a greater popularization of field investigations, since to depend upon the personal account of the psychopathic criminal may well give one a valuable clue to his personality, but will not produce that dependable record of his habitual mode of reaction to environmental factors which is so essential for a convincing diagnosis of psychopathy.

Birnbaum's book consists of three general parts. In the first part of the book, after a discussion of the well known theories of degeneracy and its etiologic significance in psychopathy, as well as that of the various injuries and toxins to the germ plasm, he devotes some three hundred pages to a delineation and evaluation of the various traits of character which compose the very protean picture of the psychopath. He undertakes in this part of the book the outlining of what he terms "a psychology of the psychopathic criminal" by means of a painstaking delineation of the manifold clinical pictures of psychopaths; next, the definition of the type of constitution and criminal personality which these traits give rise to, the form in which these personalities come to light in society; finally, the conditions and circumstances under which they become criminal, and the kind of crimes in which they tend to indulge.

One justly shrinks from the attempt to bring within the scope of a review a satisfactory digest of the large amount of instructive matter embraced within this part of the book, and the conviction is not at all unjustified that no matter how well one might succeed in doing this the original must suffer. For the difficulty lies not only in the putting into a few words the very detailed symptomatologic descriptions, but in the fact that these are given in the best perspective and in their most natural setting in the very rich casuistic material which is contained in the book. But case histories cannot be transcribed into a review.

The author devotes separate chapters to such topics as the general emotional dullness of the psychopath, his pathological inconsistency and infirmity of character, his pathological levity and the frivolity of the psychopathic constitution, the pathological degree of impressionability and suggestibility which makes of the psychopath such a ready victim of bad example and guidance, the instability and weakness of will which are responsible to so large a degree for the lives, without goal or definite object, so characteristic of the psychopath, the heightened affectivity, the pathological irritability, the queerness, oddness and pathological passionateness of these natures, the over-valuations and pathological lusts and cravings to which they are slaves, the peculiar affective dispositions, impulses, trends and instincts which serve as such strong directives of the psychopath's behavior, the various habituations, or rather manias, which seem to be so essential to gratify the emotional cravings of the psychopath—such as the passion for gambling, collecting various objects, senseless buying and speculation, the various psychic compulsions and sexual psychopathies, or pathological sex trends, the pathological ego-consciousness and paranoidism which serves so frequently as a *casus belli* for serious conflicts with their environment, the pathological fluctuation of mood which is expressed now in chronically and constitutionally depressed and anxious natures, and again, in constitutionally manic personalities, the penchant for the phantastic and fear or timidity of reality, the dreamers, swindlers, pathological liars and those exquisitely interesting and troublesome hysterical natures, the querulousness and intolerance, the ready soil for pseudo-delusional or delusional interpretation of events which is assisted by the great facility for fallacious sense perceptions, and finally, the moral obtuseness or moral idiocy which we shall discuss a little more in detail, since it is of particular significance in a work on the criminal.

The author very aptly avoids entering into a detailed review of the pros and cons of the concept of "moral idiocy." It is to be expected that Birnbaum, who undoubtedly possesses a keen insight into psychopathology, should abstain from subscribing unqualifiedly to the concept of "moral idiocy" as a nosological entity. What he states is "the pathological moral defect in its entire purity and as a sole psychopathic phenomenon occurs only rarely, yes, perhaps, only exceptionally," and the familiar case of Bleuler constitutes a "unicum." Mixed forms and combinations with other psychopathic traits are the rule.

The reviewer is still to be convinced that one ever sees in actual practice an exclusive and pure defect of such hypothetical psychic unitary attribute as "morality." The total lack of any capacity to experience those warmer stirrings of the soul, those feelings of altruism and sympathy, the total inability to place one's self in the position of another, to feel with one's fellowman in his joys and sorrows, the total disregard of the rights of others, the lack of all understanding of such concepts as truth, compassion, charity, sympathy, altruism, in short, morality, the pleasure in the pain of others and in cruel torturing of defenseless creatures, the lack of any conception of ties of friendship or even blood relationship, and the total indifference to the opinion of others, etc., which characterize the moral idiot, imply a kind of retarded development and backwardness which finds its echo in spheres of the mind other than a mere restricted so-called "moral sphere." The moral idiot is idiotic in more ways than one; and whether a given idiot will acquire the distinction of being a moral idiot, depends not infrequently upon the kind of environmental contacts it has been his lot to experience.

It may add force to our contention if one were to consider for a moment how dangerously young and frail are those various acquisitions of modern man which we are wont to include under the term "morality" when considered in the light of the history of evolution. The epidemic of moral idiocy and insanity which is at this time ravaging the world is undoubtedly being justified at the source of the infection on such high grounds as patriotism, loyalty, devotion, attributes which we are wont to consider as highly moral, in normal times.

After reading Birnbaum's thoroughgoing description of the symptomatology of psychopathy one naturally expects to leave the book with some workable classification of types in mind, but the author leaves this wish ungratified. The book is singularly free from dogmatic and rigid classifications and this must be so from the nature of the subject.

The following formulations with which the author sums up the clinical part of this book are, however, of considerable help:

1. Criminal behavior is not the only and perhaps not even the most frequent manifestation of the degenerative constitution. The psychopath manifests also traits of character, some of which may be of high cultural value. In characterizing, therefore, an individual as a psychopathic or degenerative personality, one is not to conclude that because of this he is also a social menace or even criminally inclined.

2. There is no such thing as a *degenerative criminal type* in the field of psychopathy. The many and varied traits of the psychopathic constitution lead at times directly, at times indirectly, to criminality. If one desires to speak of criminal types, it might be stated that there are numerous, quite varying degenerative criminal types. One might mention, for instance, the moral idiot, the unstable, the emotionally hyperirritable, the impulsive, etc. Even such main types do not frequently occur in pure form. Instead, various combinations, mixtures and transitional states of the various traits of character are also the rule in the psychopathic criminal. Nevertheless, the various psychopathic traits of character possess a varying significance as far as their potency for criminal behavior is concerned. Traits of a markedly active tendency like pathological egotism, pathological passionateness, hypomanic temperament, etc., or moral defectiveness, or pathological impulsiveness,

play a much greater part in the causation of criminality than do others, and may render antisocial, if circumstances are favorable, individuals who otherwise are indifferent as far as criminal tendencies are concerned.

3. As may be, therefore, seen, not all criminality of the degenerative psychopathic types depends upon a moral badness or an inherent tendency to criminality, not all psychopathic criminals are morally defective, or criminal natures. One may find among them, frequently enough, people without any moral defect, at any rate without such degree of moral deficiency as may strike one as being an important part of make-up. Their criminality does not at all depend upon immoral or unmoral traits of character, but upon those which make adaptation to social life in general difficult. This is also true to a certain extent of the psychopathic recidivist, the habitual criminal, or the so-called incorrigible criminal in whom there is by no means always present a degenerative criminal *anlage* or a far-reaching, endogenous antisocial tendency.

4. Although in the last analysis the criminality of the psychopath arises from psychopathic dispositions, this endogenous factor in itself may not be of decisive significance. The external influences may be of far-reaching, yes, even of determining significance. Thus unfavorable influences of environment may cause an antisocial or unsocial shaping of the character and of the behavior in individuals of socially indifferent psychic characteristics, an antisocial shaping which would not have occurred otherwise. Thus an accidental contact, an unfortunate accumulation of unfavorable environmental factors may lead to an episodic disturbance of equilibrium, which results in criminality, a type of behavior which under average circumstances of life would not have taken place.

5. Inasmuch as psychopathy, as such, does not at all signify criminality, one cannot, therefore, speak of a parallelism between psychopathy and criminality, a parallelism which would lead one to assert that with the degree of psychopathy, or with the intensity of the psychopathy, the extent and seriousness of crime must increase. Such a profound psychopathic state, for instance, as the constitutionally depressed emotional state is not of so much importance from the criminalistic point of view as one so mild by comparison as is inconsistency.

Now, if, conversely, one endeavors to reach any deductions from the criminal behavior of the individual as to personality, or possibility of the existence of a psychopathic constitution, the following formulations of Birnbaum may serve as a guide.

1. Crime and criminal tendencies in themselves demonstrate nothing so far as psychopathy is concerned, not even prolonged criminality, recidivism and habitual criminality. Recourse to crime means nothing in this respect, because all of these manifestations of behavior may also occur in normal individuals. Of course, one occasionally sees that criminal behavior as well as antisociality constitutes the most clearly

developed, yes, even the only characteristic and expression of an existing psychopathy.

2. Even the seriousness of the crime does not furnish a sure criterion for the existence of a psychopathic constitution, although the fact cannot be overlooked that it is these personalities that are most frequently involved in the most serious crimes, such as murder, etc.

3. The absence of moral influence in connection with a criminal act, or, in other words, an endogenously determined criminal behavior, is not conclusive proof of a degenerative origin, because even in the moral criminal it is frequently an inner endogenous disposition which is responsible for the criminal act (affective, emotional crimes, etc.).

4. Juvenile criminality although so frequent a characteristic of the degenerative nature, is not sufficient proof of a psychopathic *anlage*, just as little as is the frequently emphasized irreformability and failure of the various punitive measures, because one must not forget that such traits are also present in the moral, habitual and business-like criminal, if such an individual happens to be born and reared in an unfavorable environment and acquires fixed criminal habits from childhood on.

5. Periodic criminality, which occasionally takes place in psychopaths, and is dependent upon inner organic reasons (abnormal fluctuations of mood, developmental difficulties, etc.) possesses altogether too little in itself that is characteristic and tangible to justify considering it as proof of a degenerative origin.

Thus, criminal characteristics as such, no matter of what nature they may be, never suffice in themselves to characterize an individual as psychopathic or degenerative. Criminality in itself cannot without further ado be considered as a stigma of degeneracy.

One would very much like to continue with as free and extensive consideration of the two remaining portions of Birnbaum's book, but this would unquestionably lead us far beyond the natural limitations of a review. Besides, the remaining portions of the book deal with subjects of a strong local significance. Thus, the second part deals with psychopathy and legal procedure, and the third part with the administration and care of the criminal psychopath. The author devotes a considerable portion of the remainder of the book to a discussion of those definitely psychotic episodes or manifestations which are apt to develop in the psychopath as a result of his contact with the law and imprisonment; in other words, with various psychotic conditions which have been designated as prison psychotic syndromes. The author does not add much that is new in this connection, but it may not be amiss to emphasize more particularly the great rôle which environment plays in eliciting these conditions. The reviewer has been for some time past inclined to insist upon designating these conditions as prison psychoses, not because they constitute any well defined nosological entity, but because the prison *milieu* is of such decisive importance in the production of these conditions. He has been strengthened very much in this belief by his experience of over a year at Sing Sing Prison, where there is a singular freedom from such psychotic reactions; in fact, only two or three cases have been observed thus far of mental disease which might be attributed to the prison *milieu*. The reason for this must be obvious to anyone who is familiar with the type of administration and régime which exists at Sing Sing. Here the freedom from unnecessary oppression and suppression of the individual prisoner, the opportunity for self-expression which is offered him by the various activities as a member of a self-governing civic body, tend in an unmistakable degree to remove those serious and chronic stresses which are responsible for the psychotic reaction in the poorly organized psychopathic personality. There is no reason to believe that the percentage of abnormal individuals in this institution is smaller than it is in other similar institutions, and yet the percentage of mental disorders which develop within the prison is very insignificant indeed.

Before closing, the reviewer desires to express the hope that some enterprising individual may undertake to translate Birnbaum's very valuable book into English.

BERNARD GLUECK.

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LIBRARY NOTES

The Library of the National Committee for Mental Hygiene, at the end of its second year after organization was completed, contains 575 books and about 4,300 pamphlets on mental hygiene, mental disease and defect, criminology, social hygiene, abnormal psychology and many other related subjects.

The Library is open to all persons interested in these subjects, and books may be borrowed upon presentation of proper references.

In addition to its collection of books and pamphlets, the Library contains over 100 sets of periodicals. These are indexed to date in the card catalogue and are available for reference and research work at any time during Library hours.

The Committee keeps in stock quantities of its most valuable pamphlet material for distribution to organizations, institutions and individuals interested in mental hygiene and related subjects. These pamphlets may be had upon application to the Librarian.

The Library is open every week day from 9 A.M. until 6 P.M. except on Saturdays when it closes at 1 o'clock.

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MENTAL HYGIENE will aim to bring dependable information to everyone whose interest or whose work brings him into contact with mental problems. Writers of authority will present original communications and reviews of important books; noteworthy articles in periodicals out of convenient reach of the general public will be republished; reports of surveys, special investigations, and new methods of prevention or treatment in the broad field of mental hygiene and psychopathology will be presented and discussed in as non-technical a way as possible. It is our aim to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials, and students of social problems will find the magazine of especial interest.

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MENTAL HYGIENE

VOL. III APRIL, 1919 No. 2

MENTAL DISEASE AND DELINQUENCY

A REPORT OF A SPECIAL COMMITTEE OF THE NEW YORK STATE COMMISSION OF PRISONS*

Prepared with the Assistance of

V. V. ANDERSON, M.D.

Psychiatrist in Charge of Special Work in Mental Deficiency, The National Committee for Mental Hygiene

INTRODUCTION

THE price paid by society for its neglect of the criminal has never been adequately estimated. Neither in dollars and cents nor in sorrow and cost of wasted and frequently vicious lives has half the story ever been told.

An enormous financial burden is carried by every state of the Union in its fight against crime. State and city budgets give startling evidence of the vast expense which criminality is to society, this being understood to be the largest single item in the public budget. To illustrate:

The cost of the detention, indictment, trial or other disposition of the average felon is conservatively estimated at $1,000. On this basis, the 2,279 felons received into the state prisons during the year 1917, cost the state approximately $2,279,000. Of these individuals 87 per cent had served previous terms and by their release into the community and return to criminal habits the state spent approximately two million dollars to dispose of them again and it continues to spend that amount each time it undertakes to convict this particular group of repeaters. Nothing can be accomplished in the way of permanent good for all this expenditure, if the criminal has not been deterred from repeating his criminal acts.

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*At a meeting of the New York State Commission of Prisons, held June 4, 1918, a resolution was adopted, directing that an investigation be made on the subject of mental disease and delinquency, by a committee of the Commission. In accordance with this resolution, a committee was appointed consisting of Hon. Frank E. Wade, Hon. John S. Kennedy, Hon. Sarah L. Davenport, Hon. Allan I. Holloway and Hon. George W. Davids. This committee, assisted by Dr. V. V. Anderson, formerly Medical Director of the Municipal Court of Boston, made a state-wide investigation as directed, into conditions in the penal and correctional institutions, and into the clinical work connected with the courts, taking the testimony of judges, medical experts, psychiatrists and others, and collecting available data and statistics of the mental examinations of prisoners and delinquents in this and other states. This report sets forth the findings of the committee together with its recommendations to the State Commission of Prisons.

New York State in 1917 received into its penal and correctional institutions 133,047 prisoners, 60 per cent of whom had served previous commitments.

Massachusetts in a given year received into its institutions 25,820 prisoners, 57.4 per cent of whom were repeaters; the total number of previous commitments being 92,443, averaging six sentences for each recidivist.

Justice Rhodes of England, writing in the *British Medical Journal*, asks, what can it mean that of 180,000 convictions in a given year, more than 10,000 have been convicted upwards of twenty times before.

Wherever our investigations have led us, the startling and depressing facts of recidivism stand out as a proof of the complete breaking down of the social security furnished by the state, in that it has failed to repress crime through the rehabilitation and readjustment of the criminal.

A most hopeful feature of the whole situation, however, is the widespread interest shown in the entire subject, and the existence of powerful forces bearing in from all sides, tending to greater enlightenment upon the problems of crime. Whether these forces have come from law or medicine, or psychology, or social or public agencies, they have all contributed to a better understanding of the criminal and the problem he presents.

Facts of unquestioned value are already at hand which go far toward explaining many past failures in readjusting the criminal. In New York State, reports coming from the State Reformatory at Elmira, the State Reformatory for Women at Bedford Hills, and Auburn and Sing Sing Prisons, speak in no uncertain terms of conditions found with such a high degree of frequency among prisoners, particularly among recidivists, as to make clear a definite relationship between delinquency and mental disease and defect.

Dr. Bernard Glueck, in the first annual report of the Psychiatric Clinic in collaboration with Sing Sing Prison, states that "of 608 adult prisoners studied by psychiatric methods out of an uninterrupted series of 683 cases admitted to Sing Sing Prison within a period of nine months, 66.8 per cent were not merely prisoners but individuals who had shown throughout life a tendency to behave in a manner at variance with the behavior of the average normal person, and this deviation from normal behavior had repeatedly manifested itself in a criminal act." Further, "Of the same series of 608 cases, 59 per cent were classifiable in terms of deviation from average normal mental health. Of the same series of cases 28.1 per cent possessed a degree of intelligence equivalent to that of the average American child of twelve years or under."

Such findings confirm similar reports coming from prisons, reformatories and courts throughout the country as indicated in the tables which follow:

Table I—Inmates of Prisons Exhibiting Nervous or Mental Abnormality

Institution	*Authority*	*Number of cases studied*	*Percentage found to have nervous or mental abnormalities*
Auburn Prison (N. Y.)	Dr. Frank L. Heacox	459	61.7
Sing Sing Prison (N. Y.)	Dr. Bernard Glueck	608	59.0
Indiana State Prison	Dr. Paul E. Bowers	100	45.0
Massachusetts State Prison	Dr. A. Warren Stearns and C. C. Rossy	300	34.9

From this table it is seen that at least 50 per cent of the inmates of state prisons are suffering from some form of nervous or mental disease or defect.

Table II—Inmates of Reformatories and Houses of Correction Exhibiting Nervous or Mental Abnormalities

Institution	*Authority*	*Number of cases studied*	*Percentage found with nervous or mental abnormalities*
N. Y. State Reformatory, Elmira	Drs. Frank L. Christian and John R. Harding	400	58.0
Mass. State Reformatory (for men)	Dr. Guy G. Fernald	1,376	59.0
Mass. State Reformatory (for women)	Dr. Edith R. Spaulding	500	63.0
House of Correction of Holmsburg, Pa.	Dr. Louise S. Bryant	100	69.0
Western House of Refuge for Women, Albion, N. Y.	Dr. Jessie L. Herrick	185	82.1
Westchester County Penitentiary	Dr. Bernard Glueck	225	57.0
Massachusetts Reformatory (women)	Jessie D. Hodder	*5,310	72.2

* Women criminals of Massachusetts either on probation or sentenced to institutions, 1915

The foregoing figures show not only the number of persons with intellectual defect but include cases of insanity, epilepsy, psychopathic personality, drug deterioration, alcoholic deterioration and other abnormal nervous and mental conditions, all of which seriously handicap the individual in his ability to adjust himself to the conditions of normal living. All of these mental conditions are most important in considering any real constructive attempt at rehabilitating the criminal.

One of the most important, if not the most important group of which society needs to take cognizance, is the feebleminded. The feebleminded furnish the substantial nucleus of that most expensive body of individuals who clog the machinery of justice, who spend their lives in and out of penal institutions and furnish data for the astonishing facts of recidivism—facts which are serving to awaken our social conscience to the need of more adequate treatment under the law for repeated offenders. It is of this group that Dr. Walter E. Fernald has so well said: "Feeblemindedness is the mother of crime, pauperism and degeneracy. It is certain that the feebleminded and their progeny constitute one of the great social and economic burdens of modern times."

The following tables, showing the percentage of inmates of prisons, reformatories and other correctional institutions, that are feebleminded, are most significant.

Table III—Inmates of State Prisons Found to be Feebleminded

Institution	*Authority*	*Number of cases studied*	*Percentage feebleminded*
Sing Sing Prison (N. Y.)	Dr. Bernard Glueck	608	21.8
Auburn Prison (N. Y.)	Dr. Frank L. Heacox	459	35.6
Mass. State Prison (men)	Dr. A. W. Stearns and C. C. Rossy	300	22.0
Joliet Penitentiary (Ill.)	Louise and George Ordahl	*49	28.5
Auburn Prison (women)	Mabel R. Fernald, Ph.D.	*76	25.0
Indiana State Prison	Dr. Paul E. Bowers	100	23.0
San Quentin (Cal.)		150	30.7

Of the inmates in prisons throughout the country, where studies have been made, 27.5 per cent are found to be feebleminded.

Table IV—Inmates of Reformatories Found to be Feebleminded

Institution	*Authority*	*Number of cases studied*	*Percentage feebleminded*
N. Y. State Reformatory for Women, Bedford Hills	Social Hygiene Laboratory	335	31.9
Massachusetts Reformatory	Dr. Guy G. Fernald	1,376	20.2
Massachusetts Reformatory for Women	Dr. Edith R. Spaulding	500	16–45
Western House of Refuge for Women, Albion	Dr. Jessie L. Herrick	185	33.5

*Women.

Table V—Inmates of Penitentiaries and Workhouses Found to be Feebleminded

Institution	*Authority*	*Number of cases studied*	*Percentage feebleminded*
N. Y. County Penitentiary	Mabel R. Fernald, Ph.D.	106	26.6
N. Y. City Workhouse (Blackwell's Island)	Mabel R. Fernald, Ph.D.	95	42.7
Westchester County Penitentiary (N. Y.)	Dr. Bernard Glueck	225	33.0
Columbus, Ohio, Workhouse	A. R. Gilliard	100	33.0

Table VI—Inmates of Industrial Training Schools Found to be Feebleminded

Institution	*Authority*	*Number of cases studied*	*Percentage found feebleminded*
Berkshire Industrial Farm (boys)	Dr. Clinton P. McCord	150	11–35
State Training School of California (boys)	J. Howell Williams	215	32.0
State Training School for Girls (Ill.)	Louise and Geo. Ordahl	482	22.0
Preston School of Industry, Ione, Cal	Fred H. Allen	382	36.4
State Industrial School for Girls, Cal.	Ada C. Bowler	75	34.0
State Training School for Girls, Hudson, New York	Edna G. Bridgeford	...	50.0

From the foregoing tables it is seen that 31.4 per cent of inmates of reformatories, training schools, workhouses and penitentiaries are found to be feebleminded.

It is clear from Tables I and II that within the prisons, reformatories, penitentiaries and workhouses throughout the country there is found a large group of prisoners who exhibit nervous and mental abnormalities, who are mentally crippled or mentally ill. Fifty per cent of the inmates of these institutions require much more specialized and much more individualized treatment than is afforded by the ordinary routine methods employed in the average penal institution. This is not a sentimental consideration but a practical measure looking toward social security. Laying aside the humane element involved, the paramount interests of society are jeopardized if we ignore the well known facts of individual differences.

In Tables III, IV, V and VI this point is illustrated. Feebleminded delinquents, as the foregoing tables will show, comprise from 27 to 29 per cent of the inmates of penal and correctional institutions throughout the country. Just what sort of a problem the seriously delinquent feebleminded person may present is seen from the following study undertaken in connection with the Municipal Court of Boston:

The careers of 100 feebleminded delinquents were intensively studied; the case histories were taken from the court files alphabetically, no other selection being required than that each individual should have been diagnosed feebleminded. The 100 persons in this particular group were arrested 1,825 times; record cards dating further back than five years were not gone into though many of the hundred had had earlier court records.

The futility of employing for this group measures intended for those capable of profiting by experience is shown from the following facts:

These delinquents in court were discharged after short periods of detention or judicial reprimand a great many times but they returned with unfailing certainty to be handled over again. They were placed on probation 432 times, but had to be placed on inside probation, that is, within institutions non-penal in character, 118 times. Of the remaining probationary periods, 220 were unsuccessful, the individuals again having to be surrendered to the court, making in all not quite one successful probationary period for each of these 100 individuals. The chances were better than four to one against any one of these individuals conducting himself normally for a six months' probationary period.

The court, in addition to probation for these individuals, tried penal treatment. They were sentenced 735 times, their sentences aggregating in fixed time 106 years' imprisonment, exclusive of 250 indeterminate sentences to the reformatories. But this did not in any way suffice to change the course of their careers.

Finally as an explanation of all this maladjustment, examination disclosed that none of these 100 persons possessed a degree of intelligence above that of the average American child of 12 years. About 75 per cent had the mental level of children under 10 years. Investigation into the past histories disclosed the astounding fact that 75 per cent had never been legitimately self-supporting. Worst of all, so far as society's responsibility is concerned, 73 per cent of these persons, though having ample opportunities for common-school education, beginning school at the usual age and leaving at the age of 14, 15 and 16 years, were never able to get beyond the fifth grade in school.

How much more profitable would it have been if the condition from which these persons were suffering had been recognized during the school period when a chance existed in each and every case either for some advance along the lines of proper habit-training, thereby saving much economic waste, protecting society as well as these individuals themselves from their weaknesses and making them useful members of the community, or for placing them in a limited environment suited to their special needs!

So far in this report we have endeavored to emphasize two things:

1. That the recidivist is the real problem in the prevention of crime; in him we have failed to accomplish that which we set out to achieve.

2. That an important and probably the most important underlying causative factor in this failure to profit by such experience is the defective mentality by which the recidivist is so commonly handicapped. In this connection recent studies* made of a group of 100 immoral women and a group of 100 drunken women showed that among the immoral women 39 per cent of first offenders, 47 per cent of second offenders and 84 per cent of recidivists were suffering from some form of mental or nervous handicap; that among drunken women 35.4 per cent of first offenders and 82.2 per cent of recidivists exhibited some nervous or mental abnormality. The relation between the mental condition of these persons and the frequency of their offense is obvious.

SITUATION IN NEW YORK STATE

Table VII—Percentage of Inmates of Certain New York Penal and Reformatory Institutions Exhibiting Nervous and Mental Abnormalities

Institution	*Authority*	*Percentage exhibiting nervous and mental abnormalities*
Sing Sing Prison	Dr. Bernard Glueck	59.0
Auburn Prison	Dr. Frank L. Heacox	61.7
Clinton Prison	Dr. V. V. Anderson	60.0
Auburn State Prison (for women)	Mabel R. Fernald, Ph.D.	25.0†
Westchester County Penitentiary	Dr. Bernard Glueck	57.0
New York State Reformatory	Dr. Frank L. Christian and Dr. John R. Harding	58.0
New York State Reformatory for Women,	Mabel R. Fernald, Ph. D.	31.9†

The existence of mental disease and deterioration, intellectual defect, psychopathic personality, epilepsy and the like, in a fairly large proportion of the inmates of these institutions makes clear and obvious how futile it is merely to go on blindly administering the law instead of endeavoring to solve the problems these individuals present. A similar situation in the treatment of disease would consist in sending all sick persons regardless of their disease to hospitals to be given the same treatment, fixing in advance the length of time they were to remain there and at the end of this arbitrary period sending them out without any reference to whether they were well or not. Are we not following the same lines in locking up criminals and then turning them out, and then locking them up and turning them out again, without any reference to whether our purpose in locking them up has been attained; or whether they are any better fitted to assume their normal relation to society on the day they leave prison than they were the day they entered it?

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* V. V. Anderson, M.D., and Christine M. Leonard, M.D. The Immoral Woman as Seen in Court: a Preliminary Report. *Boston Medical and Surgical Journal*, 177: 899-903, December 27, 1917. Drunkenness as Seen Among Women in Court. MENTAL HYGIENE, 3: 266-74, April, 1919.

† Feebleminded.

Even where scientific studies and classifications have been undertaken, if these have not been made the basis for treatment, nothing in the way of benefit to the individual or security to society can be said to have been accomplished by such investigations. The mere knowledge of the existence of these conditions, the mere labeling of a certain number of prisoners as intellectually defective or mentally diseased or deteriorated, or psychopathic, is not enough. Such knowledge should be made the basis for treatment. Constructive efforts should be made to rehabilitate these persons in the light of the needs of each individual prisoner, not only of his disabilities, but of his capabilities and his adaptabilities. The machinery of the penal institutions should be so organized as to enable it to carry into effect such recommendations as would be suggested.

But as indicated from the foregoing tables, such a heterogeneous group as is to be found in all penal institutions, composed as it is of types requiring entirely different lines of treatment, would preclude the possibility of carrying out this program in every one of the units of a penal system in a great state like New York; therefore, those who have given thoughtful consideration to the problem feel that the situation could be handled best by establishing clearing houses with medical clinics, through which would pass all prisoners sentenced to prison and reformatory institutions.

CLEARING HOUSE AT SING SING

Every sentenced male felon first should be admitted to the clearing house now being provided at Sing Sing Prison. Here he should be kept under observation for a period of three or four months, studied physically and mentally, given the very best in the way of modern medical treatment, and placed under intensive vocational study and training for as long a period of time as necessary to enable the administration to define clearly the problem which he presents. Soon after his admission he should be presented at the medical clinic for a rigid and thoroughgoing physical and mental examination. The most approved clinical and laboratory facilities known to modern medicine should be used in these examinations. The aim should be not only the physical rehabilitation of the prisoner and the delineation of those underlying causative factors responsible for his delinquent career, but an effort should be made also to discover the abilities of each prisoner in order to determine whatever qualities he may possess, the cultivation of which might enable the penal administration to restore him to his normal relation to society as promptly and as permanently as possible.

* Undoubtedly many criminal careers are due less to inherent biological defects in make-up than to the repeated exposure throughout life to unfavorable environmental and developmental conditions, forming in this way many of the character traits and personality difficulties so commonly responsible for delinquent behavior.

The most important phase, therefore, of the examination at the clinics would be a study of the personality and life history of the individual. While psychological tests would necessarily be given, since a cross-section view is most helpful, nevertheless the greatest emphasis should be placed on the careers of these individuals as seen in the light of modern psychiatric knowledge of behavior.

It is no doubt needless to add that, inasmuch as the very nature and purpose of this clearing house would be essentially medical, all its clinical activities should be under medical direction. Further, it may be well to emphasize that no one phase of the work such as sociological, psychological, psychiatric and physical should constitute an independent unit, if anything like a well rounded study and an intelligent and understanding treatment of each individual is the aim. Only by making each one of these various aspects a coordinate part of a comprehensive scheme in the study and treatment of each and every individual prisoner, can successful results be obtained.

As stated before, the average length of sojourn at the reception prison would be three or four months; some would not require so long a period, while in other cases a clear definition of the problem presented would necessitate a much longer period than three or four months. After this period of examination it would be possible to supply to other prisons "a stream of healthy, sane, able-bodied prisoners" who have received treatment for physical defects and disease, whose mental condition has greatly improved and who by intensive vocational study and training, would be able to acquire in other prisons skill in that trade or occupation best suited to their abilities. Those discharged from the clearing house should be distributed to the other prisons in the following manner:

1. All cases of tuberculosis should be transferred to the tuberculosis hospital at Clinton Prison.
2. Those sentenced to the reformatory at Elmira would be transferred to that institution. This in no way would interfere with the power of the court to commit to Elmira, as only the insane and those of the defective delinquent group, requiring very special care and treatment would be transferred elsewhere.
3. The younger and more normal male felons receiving state prison sentences should be transferred, as Dr. Glueck has said, "after having been well started in acquiring the trade for which they are best suited, as determined by scientific inquiry into their capabilities," to either one of the two industrial prisons of the state, Clinton or Auburn.
4. The older normal prisoners and those found incapable of learning a trade should be transferred to the agricultural prisons, Great Meadow and Wingdale, where they could make themselves most useful to the state in some form of agricultural occupations.
5. The insane who require treatment of a more or less permanent nature in hospitals for the insane should be transferred to the Dannemora State Hospital for the Criminal Insane. The more recoverable types should remain at the reception prison under proper treatment in a specially constructed pavilion.
6. There remains a very large group known as the defective delinquent group. The term "defective delinquent" is used here in a sense similar to that in which the term "insane" is used, being more of a legal than a strictly medical classification. In this group are included the intellectually defective delinquent, the psychopathic delinquents, the epileptic delinquents and the like. The individuals belonging to this group, who after pro-

longed and careful study and training are found incapable of reconstruction to a degree which would justify their release into the general community, should be committed to an institution specially suited to their particular needs, an institution for defective delinquents.

As the following table indicates, about 15 to 20 per cent of prison and reformatory inmates may well be segregated in such an institution.

Table VIII—Percentage of Inmates in Certain Prisons and Reformatories Regarded as Segregable

Institution	*Authority*	*Percentage regarded as segregable*
Auburn Prison (N. Y.)	Dr. Frank L. Heacox	17.9
Sing Sing Prison (N. Y.)	Dr. Bernard Glueck	15–25
New York State Reformatory (Elmira)	Dr. Frank L. Christian and Dr. John R. Harding	17.0
San Quentin Prison (California)	Report of San Quentin Prison	17.9
Massachusetts Reformatory for Men	Dr. Guy G. Fernald	15.5
Massachusetts Reformatory for Women	Dr. Edith R. Spaulding	24.8

The more adjustable members of this "defective delinquent" group who show capacity for reconstruction to a degree that would justify their later release into the community under close and intensive supervision should be retained at the reception prison for prolonged training as a special group and later transferred to the industrial and agricultural prisons for further training. The intellectually defective members of this group, not regarded committable to the institution for defective delinquents, who may have slight difficulties of personality, may furnish little trouble and may well be made self-supporting and later restored through intelligent parole to the community. The psychopathic members of the defective delinquent group, the neurotic, unstable, emotional, temperamental individuals suffering from serious difficulties of personality, furnish a problem far less easily solved. Those who do not break down completely under confinement and require treatment as insane, those who do not have to be committed to the institution for the defective delinquents, may be given the advantages afforded by prolonged training and may well, through the education of their inhibitions, learn to control their impulsive tendencies and emotional outbreaks to such a degree as to enable them later to be incorporated into the community, achieving more or less enduring adaptation to their industrial environment and protected from the stresses and temptations to relapse by adequate social supervision.

It would be like elaborating the obvious to call attention to the close relationship such a program bears to a real indeterminate sentence.

It is generally accepted that but for the defective delinquent group the punishment problem would almost disappear in prisons; that these individuals are the source of all disciplinary measures required. It is quite evident then that proper classification would not only be of immense value in this direction, but, what is of the greatest importance to the prison management, it would enable those agencies already existing in prisons, such as self-government, education, industrial training, etc., to be used more effectively.

CLEARING HOUSE AT BEDFORD HILLS

All that has been said relating to the need of a clearing house for the sentenced male felons of New York State may be restated with equal, if not greater, emphasis in regard to the female inmates of the state penal and correctional institutions.

The well recognized menace that venereal disease is to the general public and the high frequency of those conditions found among delinquent women are matters for serious consideration. In 440 cases studied at the New York State Reformatory for Women at Bedford Hills, 48 per cent gave positive reactions to the Wassermann test for syphilis. Of 289 prostitutes studied by the Baltimore Vice Commission, 63.7 per cent showed syphilis. At the Reformatory for Women at Framingham, Massachusetts, 75 per cent of the population were suffering from gonorrhea. At the New York Reformatory for Women at Bedford Hills 73 per cent showed the presence of gonorrhea.

The relationship that these two conditions bear to feeblemindedness need not be enlarged upon here. Venereal disease and feeblemindedness form a combination as productive of human wretchedness and misery as any scourge that has ever afflicted mankind. Twenty-three per cent of the women at the Reformatory at Framingham, Massachusetts, who were fit subjects for permanent segregation on account of mental defect, showed 90 per cent of gonorrhea and 60 per cent of syphilis.

At least 30 per cent of the population in representative penal institutions for women in New York State are feebleminded, as indicated in Table IX. No satisfactory figures were obtainable showing how large a number of the women prisoners were suffering from other pathological, nervous and mental conditions, such as mental disease or deterioration, psychopathic personality, epilepsy and the like. However, the high percentage of feeblemindedness is of itself causing many institution officials to agree with the statement made in the report of the State Hospital Development Commission, that "the really reformable type is becoming in certain reformatories an almost unknown quantity and the number of defectives already so large that the question arises whether it would not be better to make one or two of these institutions actually 'defective delinquent' institutions and continue the others as reformatories with a population that is really reformable."

Table IX—Feebleminded Women Found in Certain Penal and Correctional Institutions in New York State

Institution	*Authority*	*Number of cases examined*	*Percentage feebleminded*
N. Y. State Reformatory (Bedford Hills)	Dr. Mabel R. Fernald	335	31.9
State Prison for Women (Auburn)	Dr. Mabel R. Fernald	76	25.0
N. Y. County Penitentiary	Dr. Mabel R. Fernald	105	26.6
N. Y. City Workhouse	Dr. Mabel R. Fernald	95	42.7
Inwood House (N. Y. City)	Dr. Mabel R. Fernald	69	15.1
Western House of Refuge for Women (Albion, N. Y.)	Dr. Jessie L. Herrick	185	33.5

We feel that the establishment of a clearing house and a reception prison at the New York State Reformatory for Women at Bedford Hills, through which would pass all sentenced women felons and those of lesser offenses selected by the courts of the state, is the most intelligent solution of the serious problem now presented by the delinquent women in New York State. The Laboratory of Social Hygiene might well be developed into an institution for this purpose. All of us are familiar with the serious consequences resulting from too long a delay in receiving into proper institutions feebleminded girls after they have developed marked delinquent traits, and especially is this true during the child-bearing age. Such a clearing house would function for those institutions handling the women prisoners of New York State in the same way that the clearing house at Sing Sing would function for men.

It is further suggested that in order to make effective the findings in this clearing house, a proper arrangement of the various other institutions handling women prisoners be made. In this connection it is suggested that the State Prison for Women at Auburn be transferred to the State Farm for Women at Valatie, after being made more secure; that the Reformatory for Women at Bedford Hills be made the State Institution for Female Defective Delinquents; that the House of Refuge for Women at Albion be used only for those who are found capable of profiting by the training afforded and capable of being reconstructed to such a degree as would enable their restoration to the community.

CLEARING HOUSES FOR THE DEPARTMENT OF CORRECTION OF NEW YORK CITY

New York City, because of its extensive population, may be considered apart from the rest of the state, but all the facts deduced for the establishment of clearing houses at Sing Sing Prison and the Reformatory at Bedford Hills bear with equal force upon the needs of the Department of Correction of New York City.

For the year ending June 30, 1917, 71,528 prisoners were received in New York City institutions. A large army of physically and mentally handicapped individuals is being bandied about from institution to institution, locked up and turned out again and the process is repeated over and over. We are of the opinion that there should be established on Blackwell's Island two clearing houses, one for male prisoners and one for female prisoners, utilizing the old penitentiary for men and the workhouse for women, which plan is now under way. These institutions should be equipped with all the modern facilities suggested for the state clearing houses.

Through those two institutions should pass all the prisoners sentenced to institutions under the management of the New York City Department of Correction, and after proper study and treatment, and the character of the problem which each individual presents has been carefully outlined, they should be distributed to each of the city's correctional institutions in the light of the needs of each case.

It will be obvious that owing to the large number of mental defectives that will be found at these clearing houses, incapable of profiting by the ordinary methods provided in the existing machinery of the Department of Correction, two special institutions, one for male defective delinquents and one for female defective delinquents will be required.

PAROLE AND "AFTER-CARE"

The object after all in this more intelligent and more humane attitude towards the criminal is so to reconstruct his personality that he may be restored as promptly and as permanently as possible to his normal relation to society. In order to determine how far the prison administration has succeeded in this object, each individual prisoner when he becomes eligible for parole should be returned to the reception prison where he will be further observed, in order to determine how well this object has been accomplished. Much light on his fitness for parole and on the measures to be adopted in the after-care work given the case would be obtained through the knowledge gathered in the investigations made at the clearing house. Too much emphasis cannot be laid on this phase of the prisoner's treatment. Reformation of the offender is never fully accomplished within prison walls. At best such an environment is artificial.

The unusual success obtained in after-care work with the insane by certain psychopathic hospitals where, through the agency of a social service department, many formerly mentally ill patients have been satisfactorily adjusted to the conditions of normal living, may well serve as an example for after-care treatment of criminals, in connection with such clearing houses as are proposed. The period following the release of the prisoner is a critical one for him and may be fraught with most serious consequences to society.

PREVENTION THROUGH COURT CLINICS

Prevention is better than cure. Would it not be more sensible, more economical and more humane to prevent insanity, pauperism, prostitution, criminality and the like than to spend vast sums in undertaking to cure, or, when this was impossible, in providing ultimate custodial care?

It needs no argument to convince the average thoughtful person, that from the vast and grim procession of petty offenders passing through our lower courts, is recruited the greater portion of criminals eventually found in the prisons of this country. The large number of "repeaters" who have spent a greater portion of their lives in and out of prison, whose conduct has been in a measure due to serious abnormal conditions from which they suffered, such as mental disease or deterioration, feeblemindedness, etc., could have been discovered long before they were sent to prison, at a time when deterioration in the mentally ill and serious criminal tendencies in the mentally defective would have been more or less preventable. The state cannot afford to waste human material in such a manner or knowingly allow human beings to cause waste to other human beings in the community.

Studies have already been made calling attention to the frequency with which this same group of mentally disabled individuals is to be found in the courts. In a study made in 1917 by the Psychopathic Laboratory of the Police Department of New York City, of 502 selected cases, 58 per cent suffered from some nervous or mental abnormality. A study of female offenders by Dr. Clinton P. McCord at Albany showed 56 per cent exhibiting nervous or mental abnormalities. A study of 81 women examined in the night court of New York City by Dr. Mabel R. Fernald showed 25.4 per cent feebleminded. A study of 1,000 offenders by the Medical Service of the Municipal Court of Boston showed 23 per cent feebleminded, 10.4 per cent psychopathic, 3.17 per cent epileptic and 9 per cent mentally diseased and deteriorated. Of the 1,000 cases referred to, 456 or 45.6 per cent exhibited abnormal mental conditions. Every one of these 456 persons is a potential and probable candidate for ultimate custodial treatment.

We believe it would be practical economy to undertake proper adjustment of such individuals at a time when their condition may be recoverable, or serious delinquent tendencies preventable, rather than to wait until such deterioration has taken place or criminal habits have become so firmly fixed as to warrant custodial treatment.

How closely the problem of the mentally defective and diseased delinquent affects our courts, how seriously it hampers them in performing their protective function, is impossible, within the limited space available in this report, to discuss satisfactorily. However, a limited view of the situation as it is seen in the average lower courts may be obtained from the following table showing selected groups of problem cases studied by the Medical Service of the Municipal Court of Boston.

It may be seen from this table that among the problem cases passing through our lower courts, a strikingly large number of abnormal individuals is to be found—individuals unfitted to profit by measures intended for normal persons and as a consequence returning to the court over and over again, forming the very nucleus of recidivism.

Table X—Relationship of Mental Defect and Disease to Selected Types of Problem Cases in Court

Diagnosis	*100 Drug users*	*100 Immoral women*	*100 Shoplifters*	*100 Drunken women*	*100 Vagrants*
Normal	18	20	22	11	2
Dull Normal	20	32	12	21	8
Feebleminded	28	30	25	32	36
Epileptic	4	6	10	8	2
Alcoholic deterioration	..	2	..	7	12
Drug deterioration	14	2	..	..	4
Psychopaths	14	7	23	10	8
Psychosis	2	1	8	11	28
Total exhibiting abnormal mental conditions	62	48	66	68	90

There is no question more closely linked up with the fundamental duty of the criminal courts, the protection of society from antisocial acts, than the proper disposition of those who, through no fault of their own, are suffering from mental handicap, and who, because of their mental condition, are liable to become a burden and a menace to the community. This fact is being fully appreciated by judges throughout the country and in many places attempts are being made to secure proper medical assistance. In two cities, Boston and Chicago, special medical clinics have already been officially created within the municipal courts, contributory to a better understanding and a more intelligent treatment of offenders coming before these courts.

It is not to be expected that medical clinics in the courts can ever take the place of clearing houses in the prisons. Such opportunities for prolonged observation and investigation into the causative factors underlying careers, not to mention the advantages afforded from intensive vocational training and physical and mental rehabilitation of the prisoner, cannot be secured in the short time allowed for the study of a case in the lower courts. What these clinics can do, and most effectively do, is to act as a net or sieve for the court, to determine beforehand those who, because of constitutional defects and mental handicaps, are less likely to profit by the routine measures employed by the court in dealing with delinquents, and who, because of such pathological conditions, carry the potentialities for delinquent careers. As a result of the use of these clinics the feebleminded and mentally diseased and deteriorated persons will no longer be tried again and again on probation and after probation has failed, be sentenced for short periods of confinement in jails, lockups and houses of correction, losing thereby whatever opportunities there might have been for restoring to health the mentally sick and preventing character deterioration and criminal tendencies in the mentally defective.

Such clinics should reduce the number of criminal insane. The early manifestations of their condition would be noted on the appearance of these individuals as petty offenders in the lower courts, and through the agency of the clinics, measures would be set in motion towards restoring them to normal health.

Through the establishment of such clinics, the feebleminded—the "mental children"—passing through adult courts, whose so-called crimes have been more the consequence of neglect and ignorance on the part of the community than of any innate wickedness on their part, will be dealt with squarely on the basis of their needs as well as their deeds.

But this is only a part of the helpful service furnished by medical clinics within the courts. The large percentage of criminals suffering from physical disabilities is attested by reports coming from penal institutions throughout the country. During the administration of Dr. Katherine B. Davis, arrangements were made to give all inmates of New York City correctional institutions the same physical examination as that required for admission to the United States Army. In the Reformatory for Male Misdemeanants of New York City, where the inmates average barely 20 years of age, only 8 per cent passed the required physical examination. In the penitentiary, where the average age is greater, only 5 per cent passed the required examination. In the workhouse, where those who are "down and out" are to be found in large numbers, only 1 per cent passed the required examination.

All studies that have been made of offenders passing through the lower courts show a startling number of individuals suffering from acute and chronic physical diseases, such as tuberculosis, Bright's disease, asthma, heart disease, syphilis and gonorrhea. The vital importance of the early recognition of these conditions cannot be overestimated. Their relationship to an individual's industrial efficiency and through this to his delinquency, may be seen from the following study made at the clinic of the Boston Municipal Court.*

* V. V. Anderson, M.D., and Christine M. Leonard, M.D. A Study of the Physical Condition of One Thousand Delinquents Seen in Court. *Boston Medical and Surgical Journal*, 178: 803–07, June 13, 1918.

A group of 1,000 delinquents was studied with the purpose in view of determining what part, if any, routine physical examinations might play in the disposition of a delinquent's case in court and later in the institutions of reconstructive measures while on probation. It was found that 85 per cent of those in good or fair physical condition had been and were still self-supporting, while only 18 per cent of those found to be in poor or bad physical condition had been and were still self-supporting.

That 96 per cent of those regularly employed were found in good or fair physical condition, while only 4 per cent were found to be in poor or bad physical condition.

That 86.3 per cent of those who were rated as "never worked" were found to be in poor or bad physical condition. The chances of being self-supporting were more than four to one in favor of the individual in good physical condition.

Further, 47 per cent of these individuals, practically every other person, was suffering from syphilis or gonorrhea. Only positive laboratory findings were included.

Certainly something more than intelligent advice, short terms of confinement in prison, general supervision in the community and securing employment, is needed to solve the problem presented by the delinquent whose physical endurance is rapidly diminishing under a progressive Bright's disease, or the delinquent who is scattering syphilis and gonorrhea broadcast into the community. These may be conditions of more vital importance to his future welfare and to that of the community in which he lives than any other consideration.

The help that medical clinics will be to the court in determining the presence of these conditions and securing the proper protection to the community and treatment of the individual is obvious.

It is not necessary in such a program to emphasize the part played in the prevention of delinquency by the juvenile court. Dr. William Healy, Director of the Judge Baker Foundation of Boston, has well said:

"The determinants of delinquent careers are the conditions of youth. Observers in many quarters are united in stating that almost all recidivists, confirmed criminals, show plainly their tendencies at least by late childhood. The factors then that turn the individual toward misbehavior are those already present in childhood."

This very fact and the presence of feeblemindedness and other nervous and mental abnormalities among delinquent children, and the splendid work done in connection with juvenile courts by Dr. Healy in Boston, Dr. Helen Montague in New York City, and others, have convinced those who have given serious consideration to this phase of the subject, that the financial saving in the prevention of delinquent careers, resulting from such studies and reconstructive work as have been done through already established clinics, more than justifies the financial outlay for their maintenance, to say nothing of the humanitarian aspect of the work.

So important are those beginnings of delinquent careers as found in childhood in their relation to the whole question of criminality, that a thoroughgoing study of each delinquent child brought into court is an ideal which the state can most profitably set itself to attain.

The establishment throughout the state of mental clinics to accomplish such aims will prove to be an investment paying in dollars and cents saved from the expense of courts, prisons, reformatories and almhouses; an investment not only in the prevention of crime and poverty, but in the joy and happiness coming from well adjusted human lives. Clinics functioning not only for the courts, but for the schools and the entire community, will be a center from which radiate influences tending to prevent many of the social, mental and moral wrecks of the coming generations.

Undoubtedly from existing knowledge as to the development of personality traits and mental characteristics it will be possible, through the study of the peculiar, retarded, abnormal and subnormal children in the schools and the community, to set in motion measures for the development of desirable character traits and for the inhibition of undesirable ones; and to select very early in their careers those children in need of very specialized treatment.

It is evident in the larger cities, particularly in New York City, owing to the great number of delinquents passing through not only the adult courts but the juvenile courts, that special clinics attached to those courts will be necessary.

We note with approval that a comprehensive plan for mental clinics is being worked up into a state-wide program by the New York State Commission for the Feebleminded. Under the provisions of the Lockwood Law, the abnormal and backward child in school will be carefully studied and suitable measures applied for his readjustment before he has become a delinquent child or an industrial failure.

The various clinics throughout the state should be supervised and their activities directed, as the State Commission for the Feebleminded plans, by a state board to govern all such clinics. An important step forward in the realization of this whole program for the prevention of delinquency would be taken by the establishment of a psychopathic hospital in New York City as has been proposed by the State Hospital Development Commission. Such an institution would serve to prevent many individuals from becoming permanently disabled by mental disease, and throughout the community serve as a stimulus for better mental hygiene. It also would be of practical service in the prevention of delinquency, in that many individuals who would otherwise become serious problems for the courts and penal institutions of the state, would through the activities of such an institution be enabled to adjust themselves to the conditions of normal living.

In conclusion, the Committee desires to express its appreciation to Dr. Anderson for his very valuable assistance in the investigation and in the preparation of this report, and to The National Committee for Mental Hygiene for its cooperation and advice.

RECOMMENDATIONS

1. That all males convicted of felony and not released under suspension of imposition or execution of sentence pass through the proposed clearing house at Sing Sing Prison, and thence be distributed to each of the state prisons and the New York State Reformatory at Elmira in the light of the needs of each case.
2. That all sentenced female felons and those convicted of offenses of a lesser degree than felony selected by the court, pass through a clearing house to be established by the state at the New York State Reformatory for Women at Bedford Hills, and from this clearing house, after a period of study and reconstruction, be distributed to other state institutions for women in the light of the needs of each case.
3. The prompt establishment of the proposed clearing houses on Blackwell's Island to function for the Department of Correction of New York City in the same way as the Sing Sing and Bedford Hills clearing houses function for the state institutions, converting the penitentiary into a clearing house for men and the workhouse into a clearing house for women.

4. The establishment of a state institution for the care and treatment of male defective delinquents, providing for their commitment, release and transfer. The Eastern New York Reformatory at Napanoch is suggested.

5. The establishment of a state institution for the care and treatment of female defective delinquents, providing for their commitment, release and transfer. The New York State Reformatory for Women at Bedford Hills is suggested.

6. The establishment of an institution in connection with the Department of Correction of the City of New York for the care and treatment of male defective delinquents.

7. The establishment of an institution in connection with the Department of Correction of the City of New York for the care and treatment of female defective delinquents.

8. That all children brought before the court, charged with delinquency or improper guardianship, be examined mentally, the examinations to be made either in a clinic attached to the court, or in a central clinic to be provided, and those found feebleminded to be committed to proper institutions if in need of institutional care.

9. That all adults convicted of offenses less than felony and all adults convicted of felony and released under suspension of imposition or execution of sentence, be examined mentally at the discretion of the judge at a clinic attached to the court or at a central clinic.

10. The establishment of mental clinics throughout the state as planned by the State Commission for the Feebleminded, and the establishment of a psychopathic hospital in New York City as proposed by the State Hospital Development Commission.

11. The creation of a state board to supervise and direct the activities of these mental clinics, thereby securing proper standardization in the way of methods used and results obtained.

12. That the Legislature be requested to enact such legislation as will put these recommendations into effect.

THE RESPONSIBILITIES OF THE UNIVERSITIES IN PROMOTING MENTAL HYGIENE

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MENTAL disorders are among the most obscure diseases to which man is liable, and many problems as to their cause and nature still await solution. An important fact to realize, however, is that we have at present a great deal more knowledge about these disorders than is actually being utilized. A great deal can be done for the general hygiene of the community by merely making efficient the knowledge which we actually possess.

Some of this knowledge is very definite and simple, and furnishes very positive directions as to conduct. The knowledge that a fatal and very prevalent form of brain disease (paresis) is due to syphilis should be disseminated as widely as the knowledge of the causation of typhoid by contaminated water.

The physician who has to deal with cases of mental disorder frequently finds that the symptoms are not due to any form of poisoning or to any visible damage to the structure of the brain, but that they can only be understood as a poor and unhealthy attempt of the individual to adjust himself to the actual difficulties in his life.

The problems in face of which the patient has broken down may seem somewhat commonplace and insufficient to account for the failure of adjustment, but the latter becomes intelligible when we analyze the inner life of the individual and study those forces in the patient's nature which are most potent with regard to the determination of conduct. This study reveals to the physician how much the conduct of each individual is determined by factors of which the latter has very little inkling, accustomed as he is to look upon his life as wholly composed of conscious, purposeful activity, determined by clear, logical thought. Beneath this level of purposeful activity and clear thought, factors of the greatest dynamic importance are at work, factors which are largely responsible for the symptoms of mental disorder.

Frequently the thorough study of the patient's sickness shows that the balance of forces, which results in the mental disorder, has been largely determined by the whole development of the patient, by the experiences and habits of childhood, by the degree of assimilation of the developing instincts at puberty, by the general methods which the individual has adopted to get satisfaction out of life in the face of actual, external circumstances and his own inner difficulties. In the adult many of these difficulties of the child and adolescent still remain undigested, they appear to be forgotten because they are barred from the clear consciousness of the individual.

In the large group of cases to which the above principles apply the physician may not have learned to modify the symptoms of the developed disorder to any appreciable extent—perhaps this may not be possible at a certain stage; but in tracing the steps in the development of unhealthy habits of thought and activity he may see how, at an early period, the possibility of modification was still open. The physician, as he looks over the history of the patient, is struck by the fact that during the developing period when help might have been given no person seemed responsible for giving this help. It seemed to be the function neither of the parent nor the teacher, the family physician nor the religious adviser, to direct or correct important tendencies in the adjustment of the individual to vital demands of his life. Even when danger signals appeared in the shape of moods, wayward reactions, daydreaming, odd attachments, unwise enthusiasms, seclusiveness, unusual interest in religion or abstract questions, no serious attempt was made by any one to know what factors beneath the surface led to the observed peculiarity.

It is obvious that an accurate knowledge of the above facts cannot be directly disseminated in the same way as facts relating to syphilis, alcholism, tuberculosis. This knowledge should, however, be at the disposal of all who are responsible for directing the lines of social and educational progress. It should be part of the equipment of those who have most to do with molding the development of the rising generation. The detailed knowledge of the forces which actually are at the root of human conduct must filter down into the community from the centers which inspire alike the teacher and physician, the religious instructor and those who mold public opinion through the press; these centers are, of course, the universities.

How far do the universities fulfil their responsibilities with regard to the mental hygiene of the community? It is doubtful whether they have attained a clear recognition of the fact that a man's mind may be richly supplied with a great variety of special information, that he may have attained a high intellectual level, and yet the man's life may be rendered inefficient because it rests upon insecure foundations. An education may enable a man to solve abstruse intellectual problems, and yet leave him so hopelessly unable to cope with a bereavement, an unsuccessful love affair, difficult marriage relations, or even simple instinctive impulses that he may lose control of the direction of his life and for a period be dominated by factors which have been almost entirely repressed in his conscious life; the disorder may be so marked as to be included under the wide term "insanity."

To rear a superb intellectual structure on such a foundation is surely not an ideal education; it is like building a house on the sand, or, to speak more hygienically, it is like building a superb mansion without paying any attention to the plumbing.

It is striking to see a man of brilliant intellect, who discusses fearlessly the riddle of the universe, unable to face the fact that in his own human nature elements are still active that are derived from the brute, the savage, and the child; even the humility of the theologian may not enable him to see himself in his actual biological composition.

If the university allows the student to face the problems of his life after an education which gives him no thorough insight into his own nature and its fundamental difficulties, does it at least give the teachers sufficient insight into the subtle structure of the child's mind to enable them to realize the importance of their problems?

It is important that the teacher should free himself from the myth of the golden age of childhood and should realize what the boy thinks and feels, what he longs for, how his daydreams go, what his curiosity is about, what vague feelings and actions are prompted by the first germs of the developing sexual life, what are the conflicts in the mind of the boy, and how he faces them or avoids them.

The teacher should have at his disposal the facts relating to the emotional life of the child. He should learn that the diffuse groping of the infant and child for organic satisfaction is pregnant with forces which are going to make or mar the life of the individual, and give him his individual stamp and determine his social efficiency. In this groping for satisfaction we can trace the origin not only of the instinctive life of the individual with its nutritive and reproductive elements, but also the roots of those higher activities which give human life its special value. In tracing these higher functions to their roots we do not cease to appreciate the beauty of the flower; we are willing, however, to be practical gardeners. We wish to care for the roots, not because grubbing in the soil has any particular charm, but in order that the plant may grow up hardy and beautiful. When we study the child we see how the groping for organic satisfaction inherent in all living matter brings the child into closest contact with the mother. As the child develops, this attachment to the mother may express itself indirectly in a certain moodiness or even direct antagonism to the father. The affection toward the boy's mother is only one element in the boy's nature but it is strong enough to assert itself in numerous obscure ways, and in the adult man it still exercises its influence and modifies the sexual life at a deep level in ways which escape his own notice. One may simply refer to the well known fact that one man may remain single through devotion to his mother, while another man may marry a woman who reminds him of his mother. In the tragedy of Sophocles, in which Œdipus marries his mother Jocaste, the tremendous conflict between the childhood attachment and the adult repression furnishes the universal human motive of the play. It must not be thought that these remarks apply only to special or somewhat perverted individuals; the same elements, in various degrees, are present in the life of every one of us and manifest themselves in dreams, in casual reactions, in likes and dislikes, and in purposeful decisions, the meaning of which sometimes escapes us. The knowledge of these facts is of the greatest use in allowing us to understand the peculiar moods of the child, the occurrence of unexplained jealousies and antagonisms and wayward reactions.

Out of the vague groping for organic satisfaction of the infant there develops at an early age the first indications of what is later to be the sexual instinct; during the early period of development the sexual is as yet somewhat diffuse and poorly localized and there is a tendency of the child to find satisfaction in many directions which, if persisted in, would mean the development of a definite perversion. In every one probably, as William James remarks in his *Textbook of Psychology*, there are the germs of such possibilities. The growing individual is like a plant with numerous shoots, each one of which might become the main stem.

A healthy withdrawal of energy from the side shoots strengthens the growth of the main stem and in that direction normal development lies. The teacher should not ignore that these side shoots have been present and that, although they may not be distinctly recognized by the growing individual, they may still have latent life and express themselves in a direct or indirect way. Over-enthusiastic attachment to a comrade or to a teacher may derive its strength from childhood tendencies which in less fortunate individuals actually develop into adult perversions.

As the boy develops, the groping for somatic satisfaction becomes more clearly specialized, the range of his interests becomes wider and the thirst for knowledge leads to eager questioning. The universality of the interest of the child in questions like childbirth shows its great importance to the child. In this curiosity we see how the desire for knowledge, which we are accustomed to look upon as a somewhat abstract intellectual tendency, has its roots deep down where the roots of the sex instinct also lie.

It is wise for the teacher to study this problem of the curiosity of the child, to convince himself that it does exist, and come to some conclusion as to what is to be done with it. The teacher can hardly be satisfied with the conventional method of telling the child a silly lie, which seldom deceives the child. The teacher can hardly approve of casting an air of mystery over anything which is sufficiently important to have caused a question in the child's mind. If we must not lie and if we should not be mysterious, the teacher has to consider how he can answer the questions of the child in a way which will help the child's development. All knowledge is gained by enlarging the sphere of existing associations; the teacher may well consider what associations the child has to which an honest answer to his question may be added. The teacher may recognize that without the knowledge of a few simple, biological facts it will be difficult to give the child any useful information and it may well be a point for discussion how far a simple knowledge of biology should form an essential part of the instruction of every child. This may be a great benefit to the adolescent when personal difficulties are apt to become intense, for then the information which the young man requires will merely mean the further development of what he already has, and will not consist in a series of propositions which he finds impossible to bring into any coherent relation to the store of Latin, Greek history, English roots, or conic sections, which have represented to him the products of education. In laying due weight on biology the teacher is preparing the boy to understand in its complete setting those higher biological adjustments which are the special province of psychology.

As the boy becomes older, out of the vague groping for somatic satisfaction there develops the haunting solicitation of sexual desire. The influence of cultural environment has already impressed the boy so that these personal difficulties cannot be frankly discussed and digested. Innocent questions and general curiosity as to childbirth and sexual matters in general have elicited either a lie or surprised horror, and the boy has learned that, for some reason or other, the subject is taboo. The conflict between the various forces is necessarily severe and in the individual case is sometimes disastrous. What does most harm to the individual is not the occasional self-abuse during the developing period, but the fact that the habit should not be clearly understood and the fact that the boy endeavors in an evasive and dishonest way to eliminate its painful memory instead of understanding the factors which led to it and dealing with the difficulty in an honest, healthy way. As it causes the boy distress and a feeling of conflict he atones for it in other ways, and sometimes we see a precocious interest in religion which has no more sound basis than the fear of being honest with himself.

This becomes still more marked in cases of mental disorder, as was the case of a patient addicted to self-abuse who referred to the toilet as the "sanctuary."

Sometimes efforts are made to be frank with boys, but unfortunate methods are adopted; it seems very unwise to try to help a boy in this direction by telling him that self-abuse leads to insanity, or to use similar threats. It would be better, surely, to let the boy know that the special instinct associated with special organs is going to be one of the most important elements in his life, and is one of his highest responsibilities. He should be told that to use his organs merely for a transitory pleasure is to use them for a wrong purpose, and that it will make it probably more difficult for him to live up to his fuller responsibilities when the time comes. He should be encouraged to be careful of himself in order that, when circumstances entitle him to enter into the reproductive life, he shall do so keenly conscious of what such relations mean.

The various minor disorders which crop out when the boy is having difficulty with the sexual instinct are well worth the attention of the teacher. Parents probably have not received the necessary training with regard to this matter. The family physician probably does not have the boy under observation. The teacher has the boy under comparatively long periods of observation and should be taught to recognize the various indications that the boy is having difficulty with his life.

The teacher may perhaps be delighted with the intense application to study shown by a pupil who is by this very method endeavoring to make up for what he feels are shortcomings in a field which he dare not mention.

Quite apart, however, from the occurrence of any special disorder at this period, the mere habit of repressing difficulties without understanding them is a bad preparation for the tasks of the adult life, where the individual may have to meet more serious difficulties. The habit of repression which may lead to disaster at 30 or 40 or 50 is largely due to the education before the age of puberty.

When a young man passes into university life, is the atmosphere of the university sufficiently tonic? Does the university keep sufficiently in mind the necessity of seeing that the foundations on which the intellectual superstructure is built are solidly constructed? The universities not only have the responsibility for giving those within their walls an opportunity of organizing their life in a hygienic way, they have a glorious opportunity presented to them: the undergraduate is at an age when ferments are working in his system, when the character is still plastic, when the repressing forces of the modern cultural environment have not yet become too despotic. He has the desire and also the courage to know, and in his youthful enthusiasm to achieve great things, he can be persuaded to take difficult steps in the direction of self-knowledge. To a certain extent the undergraduate makes progress in this direction by means of frank social intercourse with his fellows, which is undoubtedly one of the soundest educational forces of the university. He, however, receives this in a form which is much too casual, and the benefit from the smoking-room may be made much more systematic and thoroughgoing in the clearer atmosphere of the lecture room, the laboratory, and the lecturer's consulting room. On the department of psychology would fall the primary responsibility for this branch of education of the undergraduate, and the psychology would need to deal with the higher types of human adjustment (feeling, will, thought, conduct) in the full light of our knowledge of the biological roots of these activities.

The problems and methods of the psychologist might have to be enlarged and the experiments of the psychological laboratory would have to be supplemented by the study of other fundamental experiments, which are seen in the home and the hospital.

The city is a great experimental laboratory and the subjects of experiment are not merely logical, purposeful men who work and become fatigued; they are actual living, illogical, lustful men who are striving to adjust themselves to their environment in such a manner that life brings them satisfaction. From the study of the results of these experiments—in other words, from the study of his patients—the physician gains a deeper insight into the structure of the adult and the relation of adult conduct to early development than can be gained in any other way.

The department of psychology, therefore, must include the study of psychopathology, and of a psychopathology which takes into consideration the most vital factors in human life. In such a department the students would have not only an opportunity of receiving systematic instruction, they would be able to work at the problems of their own individual lives and to receive useful advice from those in charge of the department. This advice might be of the greatest use with regard to the coordination of their various studies while at the university, and might guide them in the choice of a curriculum really suited to their needs and aptitudes. The work done by students in this department might be of far-reaching importance; the systematic analysis of their own difficulties and adjustments and of the development of the same by a group of students would be a contribution to psychology of a most valuable nature.

Teachers who had honestly taken advantage of such a course of study would be much better prepared to discuss seriously the important problems of general education. Having come to an honest understanding of themselves, they would be able to do much toward creating a healthy atmosphere for the discussion of various topics of fundamental importance, which at present are too frequently ignored.

If a great responsibility rests on the university for the satisfactory equipment of teachers, an equally clear responsibility exists with regard to the adequate training of physicians. The teacher cannot be expected to have the same detailed knowledge of unhealthy reactions possessed by the physician nor is he especially trained to deal with the same. The most that the teacher can frequently do is to call the attention of the parents to certain danger signals and to recommend that a medical opinion be sought.

In many cases of mental disorder, both in the young and adult, the family physician has had the opportunity of seeing the symptoms at the very earliest stage. The physician as a rule has had the education of his fellows. He has seldom received any special training in psychology, his training in the study of mental disorders has, as a rule, been of the most superficial description and has frequently been confined to a few systematic lectures on certain kinds of disorder which he is expected to name and recognize, and to a few demonstrations of patients who have possibly interested him as a medical student more from a dramatic than a medical point of view.

It is no wonder that the family physician with this equipment, with no special insight into these fundamental difficulties of adjustment to life which express themselves in odd manifestations, should be quite at a loss when confronted with rather vague and evasive symptoms, which are frequently the precursors of more serious trouble. The individual may have peculiar headaches or a change of mood or may feel suspicious or unusually irritable or may have unexplainable physical symptoms or feelings of anxiety or fear. He may have an obsession to do things an unreasonable number of times, or there may be a sudden lack of interest in life or an ungrounded jealously. The possibility of helping the patient is very much greater if the patient is seen at an early stage of the disorder and if, at this early stage, the whole situation is thoroughly gone into. It does not do to meet very definite symptoms like the above with general prescriptions. A course of tonic medicine or a sea voyage will not charm away the disorder which is due to certain difficulties, which the patient takes with him on his sea voyage, and which cannot be reached by any drug poured into his stomach.

It is obvious that the university must make provision in its medical course for adequate teaching of the whole subject of mental disorders. It should be compulsory for each medical student to have a separate course in the department of psychology.

He should have an opportunity before he leaves the medical college to examine personally and study actual cases of mental disorder. In order that such opportunities may be available, wards for patients with mental disorders should be at the disposal of the teaching staff of the university. The medical college should have either a psychopathic clinic at its disposal or psychopathic wards in the general hospital where its teaching is done. A medical man with a satisfactory grasp of the principles of psychopathology would be in a position to contribute a great deal to the mental hygiene of the community in which he lives.

It does not seem necessary to take up in detail the rôle played by the religious adviser, and by those who help to mold public opinion through the newspaper and the periodical press; they, too, may be considered as belonging to the teaching class and those of them who should have passed through a university, which fulfilled its responsibilities toward the mental hygiene of the community, would leave it with a self-knowledge which would make them very potent agents for good in creating a healthy social atmosphere.

To state briefly the points which this paper aims at emphasizing:

(1) The lack of guidance in childhood, adolescence, and early adult life is one of the causes of the development in the adult of a great variety of nervous and mental disorders, varying from frequent headaches, peculiar mannerisms, anomalies of mood, odd interests and enthusiasms, to disorders of conduct sufficiently pronounced to be called insanity.

(2) Those primarily responsible for giving the necessary guidance are the parents and teachers, the family physician and the religious adviser.

(3) The parents cannot easily be reached directly.

(4) The teachers can only take up the problem efficiently when their own education deals frankly with many problems of life which are too frequently ignored although they are of fundamental importance.

A course of psychology for teachers is quite inadequate unless it deals thoroughly with the basal forces of human nature, with the instinctive roots of conduct, and with the various surface phenomena which crop out above the surface when the instinctive life of the individual is being badly managed.

(5) The student at the university should not only have the opportunity of developing his intellectual efficiency and of casu-

ally deriving personal benefit from frank intercourse with his fellows; he should in every case have a course of instruction dealing with the fundamental problems of human life, and in this department should find a suitable opportunity for facing his own personal needs and difficulties, and placing his intellectual development on the sound basis of a healthy and clearly understood instinctive life.

(6) No medical college is fulfilling its responsibility toward the community unless it provides its students with a satisfactory opportunity of studying mental disorders in their earliest phases, and trains physicians to recognize early and to regard seriously the symptoms of disordered balance in the child and in the adult.

Brevity is the soul of wit, but also the source of misunderstanding; this brief paper may bring little conviction and cause some offense. My plea has been that the universities should aim at making men wiser, and to indicate the spirit of this plea let me quote the following passage from an author of marvelous intuition, a master of simple and accurate expression.

> "As we become wiser we escape some of our instinctive destinies. There is in us all sufficient desire for wisdom to transform into consciousness most of the hazards of life. And all that has thus been transformed can belong no more to the hostile powers. A sorrow your soul has changed into sweetness, to indulgence, or patient smiles, is a sorrow that shall never return without spiritual ornament; and a fault or defect you have looked in the face can harm you no more, nor even be harmful to others . . . whoever is able to curb the blind force of instinct within him, is able to curb the force of external destiny also. He seems to create some kind of sanctuary, whose inviolability will be in the degree of his wisdom; and the consciousness he has acquired becomes the center of a circle of light, within which the passer-by is secure from the caprice of fate. Had Jesus Christ or Socrates dwelt in Agamemnon's palace among the Atrides, then had there been no Oresteia; nor would Œdipus ever have dreamed of destroying his sight if they had been tranquilly seated on the threshold of Jocaste's abode."

THE PSYCHIATRIC THREAD RUNNING THROUGH ALL SOCIAL CASE-WORK*

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IT is clear at a glance that the title of this paper is inaccurate, for when you come to look for the psychiatric thread running through social case-work you see at once that this *thread* constitutes the entire warp of the *fabric* of case-work. Inasmuch as the adaptation of an individual to his environment, in the last analysis, depends upon mental make-up, the study of the mental life is fundamental to any activity having for its object the better adjustment of the individual. The special function of social case-work is the adjustment of individuals with social difficulties. It is the art of bringing an individual who is in a condition of social disorder into the best possible relation with all parts of his environment. It is the special skill of the social case-worker to study the complex of relationships that constitute the life of an individual and to construct as sound a life as possible out of the elements found both in the individual and in his environment. Our relations to our environment are caused by mental, physical, and economic factors existing in our own experience and in the experience of other persons. It is no matter which of these three classes of factors is considered of *primary* importance since they are all of *fundamental* importance in dealing with a case of social disorder. It would be hard to say which leg of a three-legged stool is the most necessary to our comfort. From the standpoint of treatment there is practical value in knowing which field is the source of greatest difficulty; but in the analysis of a case of social disorder, consideration of no one of the three classes of factors can be safely omitted. Furthermore in treatment, with few exceptions, some consideration of all three will be required even where one predominates.

Social workers in attempting the social adjustment of an individual draw upon the knowledge of all sciences for their own use and depend upon the skill of all other practitioners in behalf of their clients. Leaving out of this discussion the economic and physical factors of social maladjustment, let us discuss the means by which we deal with mental factors. Almost everybody acquires by experience of life a rough and ready knowledge of psychology, and most social workers study psychology as part of their general education. When in the course of our work we have a patient who is mentally sick, we call upon a psychiatrist. The question naturally arises whether it is not the psychological thread that forms the warp of social case-work with the psychiatric thread making an occasional morbid pattern. That is, can psychiatry do anything more for social case-work than treat mentally sick persons? Is it not knowledge of psychology rather than psychiatry that we need, except in the rare cases of mental disease? The analogy of physiology and medicine will perhaps help to clear up this question. It is generally agreed that the social worker needs some familiarity with the essentials of medicine, and that as a basis for such knowledge some acquaintance with physiology is necessary. If it should be granted that the social worker needs to know something of psychiatry, a previous knowledge of psychology would have to be assumed. Roughly speaking psychology tells us what the mental processes should be, psychiatry shows what these processes actually are in a given case. Psychology establishes the average or norm for our guidance, while psychiatry points out all possible variations from the normal. If all men were of the same order, psychology would be sufficient for our needs, but since human nature is subject to innumerable variations, it is necessary to understand the peculiar character of the individual before applying the principles of psychology.

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In social case-work we are dealing with individuals in the most intensive manner possible; therefore, we are immediately concerned with the particular variations of each individual. And a very large proportion of persons with whom social workers deal vary sufficiently from the average to present a psychiatric problem, that is, to call for the use of knowledge that is to be had from psychiatry and not from psychology. This fact, that a majority of social cases are psychiatric problems, is probably not yet generally recognized. It is common knowledge among us that medical problems are prominent in case-work, and few would deny that the case-worker needs to know some medicine in addition to physiology. But the recognition of the extent to which mental disorder enters into social problems has only begun to dawn upon us. Knowledge of psychology has for some years been held essential, but for the most part social workers look upon psychiatry as a subject that it is hardly safe to touch, or at any rate only after laying a foundation of "normal psychology" as they say, upon which to lay firm hold in order not to be swept away into the unpleasant morbid realms to which they imagine psychiatry will lead them. The old unhappy prejudice against mental disease which still holds sway over this generation is, of course, responsible for this prevalent misconception. But social work must be free from prejudice, if it is to take its place among professional and scientific endeavors. It is a mistake to think that familiarity with the abnormal breeds contempt for what is sound and wholesome. We turn from sickness with an increased appreciation of health. I remember how good the sunlight looked when I came out of a coal mine, yet I had felt very much at home down in the mine. Knowledge of mental disease gives added value to mental hygiene. I am sometimes asked if familiarity with psychopathic cases does not make everybody seem a little psychopathic. On the contrary, the psychopathic seem to the psychiatric social worker more like everybody else, but persons of sound personality seem more admirable than ever.

When social workers talk of working only with "normal persons," as I often hear them say, it is not clear what they mean. Several managers of large firms have told me that they employed only "normal people." We rarely use the term "physically normal," for almost no one is completely healthy or well all of the time. It is just as true that no one has a mind in perfect condition or maintains an even state of mental health. The term "normal" applied to the mentality of an individual has no exact meaning; but it is a very serviceable word if taken to mean that a person's mental condition is such that barring accidents he is likely to get on in the world without difficulties. The normal person is one who is able to adapt himself to his environment. In this sense, a person who is normal may have slight mental disorders, just as a well person may have a headache, a toothache, or a cold. We are an assembly of normal persons, but probably no one of us could claim never to have had any sort of mental or nervous trouble. A psychiatrist once assured me that if anybody believed himself to be of perfect mind, he would be ashamed to own it, knowing that he would be regarded as uninteresting. For some reason we are not entirely sympathetic toward the perfect in nature.

The actual number of acute psychiatric problems to be found among the cases of all social agencies is far larger, I believe, than we are accustomed to think. Fifty per cent of the cases cited by Miss Richmond in *Social Diagnosis* present clearly psychiatric problems, and another 15 per cent strongly suggest a psychopathic condition. In many of the 35 per cent where mental disorder is not indicated, the brief mention of the case does not show its absence conclusively. So that of these cases taken from various agencies and cited in illustration of a variety of points, over one half at least probably called for social psychiatric treatment.

A recent review of 50 consecutive applications to the Boston Associated Charities showed 36 individuals in these 50 families who were probably psychopathic, 24 of these were clearly so, and 12 were strongly indicated to be so. In 14 cases the personality of one or more members of the family was not indicated. It is not safe to assume that mental difficulties do not exist when not recorded in social records; so that 36 persons in 50 cases is probably below the true figure.

Fifty consecutive admissions to the placing-out department of the Boston Children's Aid Society showed 45 persons with mental disorder indicated—10 children, 22 parents, and 6 near relatives clearly psychopathic, and 7 parents presumably so. Nineteen of the 50 were cases of infants, so that the figure 45 psychopathic persons in 50 cases may be below the fact. Of 297 children in the care of the Society on May 1, 23 were known to be psychopathic and 29 were under observation, making 52 children requiring social psychiatric treatment—17½ per cent.

Another children's agency in Boston, which gives routine tests, the New England Home for Little Wanderers, found in 100 consecutive admissions, 50 children of normal intelligence and 50 who required further observation or special care, 4 of whom were feebleminded. In two other studies made by this agency of 201 children and 174 children, the percentage of psychiatric problems was 45.3 per cent in the first group and 45.9 per cent in the second group.

The Church Home Society in Boston, a placing-out agency for children, has adopted the practice of a routine psychiatric examination for all children admitted to its care. A psychiatrist is attached to the staff of the Society, who not only examines but observes and treats the children in its care. The psychiatrist's report on 100 children shows 44 requiring psychiatric treatment.

The routine mental examination practiced by this agency is regarded by some social workers as an unnecessary luxury and in the nature of a fad; but since nearly half of its children are found to be psychiatric problems, the practice would seem to justify itself. The Secretary of the Society, Miss Hewins, told me that the agency profited not only by the advice given in cases of mental disorder but also from several by-products of the psychiatric clinic, (1) detection of superior ability in children, to whom exceptional educational opportunities were given, (2) advice to visitors in regard to training normal children, (3) improvement of records due to the necessity for more exact information required for psychiatric study.

Several years ago in a paper entitled *Routine Mental Examination as the Proper Basis of Practical Measures in Social Service: A First Study Made from 30,000 Cases Cared for by 27 Organizations in Boston and Surrounding Districts,* Miss Helen Wright, assistant in the Social Service Department of the Boston Psychopathic Hospital, compared the reluctance of social agencies to adopt routine mental examinations to the early opposition to the idea of investigation. She said, "When pioneer workers in organized charity and reform movements urged *investigation* as the only scientific basis for rendering charitable assistance of any kind, at first an investigation was made very guardedly and very superficially by the societies then in a position to make one. As time went on, certain cases were inquired into carefully as a matter of principle, but others were put aside as 'too sensitive to be investigated,' 'evidently all right.'" No efficient agency today would dispense with the routine inquiry into the social condition of a client, but few agencies are yet persuaded of the necessity for routine inquiry into the mental condition, which might seem to be even more important as a basis for social treatment. Miss Wright found 3 per cent of mental cases in family agencies, 4.5 per cent in children's agencies, 7.9 per cent in temporary homes for women. Two agencies for unmarried mothers that made a practice of routine mental examinations showed 17.9 per cent and 23 per cent of mental cases respectively. The other agencies detected mental disorder only when some acute condition made an examination necessary, and without question were dealing with a higher percentage of mental cases than they were aware.

A study of 2,600 admissions at the Boston Psychopathic Hospital showed that 30 per cent of the cases were known to social agencies before admission, over half of this number to more than one agency, 15 per cent of them to five or more agencies. In the social work for these 800 odd cases 139 agencies were involved before they came to the Psychopathic Hospital. It is not known of course at what point the agencies recognized mental disorder in these cases; but the figures are an indication of the amount of social work that may be required by frankly psychopathic patients.

The greater part of the case-work of the social service of the Psychopathic Hospital is essentially the same as the work of other social agencies. For example, in 100 current intensive cases there are 65 cases presenting family problems such as might have fallen to the lot of a charity organization society. There is a misconception, which is sometimes heard, that the psychiatric social worker has a different function from other social workers. She has exactly the same function of social case-work, including, as the figures above quoted indicate, family case-work. The characteristics which differentiate the psychiatric social worker are (1) knowledge of nervous and mental disorders, (2) experience with psychiatric cases, and (3) a point of view which seeks for the causes of conduct in mental factors.

Most social agencies will tell you that their files are full of cases that would have received different treatment if the psychiatric problem had been discovered earlier. The loss to the client as well as the waste of effort on the part of the agency caused by misdirected treatment in such cases is obvious.

Social case-work habitually relies upon psychiatry for advice concerning the care of persons with mental disorder. This advice is indispensable and very important. But perhaps even more important is the help that psychiatry can give the social worker in understanding human nature and in dealing with the many varieties of human personality that come before the social agencies. Personalities that would be considered normal frequently present many irregularities and contradictions. When we have come to understand these peculiarities as they appear in exaggerated form in psychopathic cases, we can more readily understand them in the average person. Besides frankly psychopathic cases, the social worker deals with persons whose apparently slight peculiarities may be the result of some marked psychopathic trait, with other persons who have very mild degrees of psychopathy, and with still other persons who are approximately normal in all mental characteristics. Whether we are dealing with pronounced psychopathic traits, or minor peculiarities, or normal mentality, the psychiatric point of view is invaluable in social case-work. By the psychiatric point of view I mean the habitual recognition of mental causes of conduct together with some knowledge of the nature of the mental processes that may cause conduct disorder.

The social worker who has completely acquired this attitude of mind will, to begin with, secure in the original investigation of a case information concerning the mental life and conduct of the individual which will give her a better knowledge of his personality than most social records now reveal. Through history and subsequent observation along the same lines, cases of marked mental disorder will be detected as early as possible. As a rule we wait until some acute mental trouble has developed before calling upon a psychiatrist or giving special consideration to the mental condition in our cases. Frequently cases come to the Psychopathic Hospital, through some accident or other, that have been dealt with by social workers for years without recognition of the mental disorder. A young woman, the mother of an illegitimate child had been a "difficult case" in various agencies for seven years, and 24 different agencies had been interested in her family. During the six months that the social service had supervision over her, she got on fairly well within the limitations of her psychopathic make-up.

Sometimes the social workers from other agencies find it hard to believe that certain patients at the Psychopathic Hospital are cases of mental disorder. At a special clinic for medical social workers a woman was presented who had been brought to us after an attempt at suicide. She had been at odds with family, friends, church, employment, and with herself, and had been drinking and fabricating. She told the story of her difficulties and how she had regained her position in life with the help of the social service in a straightforward, rather attractive way. Afterwards a prominent social worker told me that she thought we should have presented a different sort of case, for, she said, "that woman is just like all the people we are dealing with." Yet this patient was distinctly a psychopathic person and required a very definite sort of psychiatric treatment.

Recently at a clinic for employment managers a man was presented who was a competent draftsman. He had come to the hospital because he felt unable to do good work and "as if he could not keep it up any longer." One of the employment managers said he thought this man ought never to have been in the Psychopathic Hospital, that he was "just like everybody else." But the physicians found in him many temperamental difficulties of a well recognized psychopathic nature, and when they treated the patient from this standpoint, he at once showed decided improvement.

Social workers have here, in the early discovery of psychopathic conditions, a boundless opportunity for mental hygiene. In addition, we have the opportunity, by applying the simpler rules of mental hygiene, to promote the mental vigor and mental development of individuals who do not require the care of a physician but are not as competent as they might be. Wrong habits of thought, badly trained emotions and instincts that may never cause a condition warranting medical attention, may interfere seriously with the happiness and usefulness of an individual. It is the duty of the social worker to attend to these things as well as to matters of diet and hygiene. After a fashion we make the attempt to do so, but as a rule without any exact knowledge of psychology and psychiatry.

Another product of the psychiatric point of view is the habit of objective observation—the study of an individual as he really is, not as we feel that we should be in his place, or as he himself tells us that he is. In social case-work we need to know as accurately as possible the nature of our client. We do him an injustice if we form a conception of him in terms of our own experience. His own account, though honestly meant, may not be accurate. Through observation of his behavior and reports of other observers upon his conduct, the best account of his character is to be obtained. When we come to the point of trying to understand him, we must necessarily think in terms of our own experience, but the objective study should precede the interpretation. We should first find out what an individual is like, and then think how we should feel and act if we were like that. This process of objective study, preceding subjective understanding, simplifies many problems in social work and promotes sympathy with our clients. Personalities quite unlike our own when studied objectively become comprehensible. We are even able to enter into experiences of psychopathic persons unlike anything that we have ever known. Not only is understanding of the individual a requisite of good case-work, but also the individuals with whom we are dealing are apt to feel the difference between genuine and assumed sympathy, so that any gain in better understanding is of great value in securing their confidence.

Another result of studying individuals from the psychiatric point of view is greater respect for their personality. When you recognize the fact that human nature is not to be rated at certain levels of merit, but is subject to infinite variations of ups and downs in character, you come to feel more respect for the high spots in even the most unsuccessful individual. If at the same time you recognize the natural causes that lead to failure you regard the individual without blame. Many unfortunate psychopathic patients, who have been censured and despised by their acquaintances, and sometimes I fear by their social workers, feel a great sense of relief when they find themselves taken from the psychiatric point of view, and with renewed self-respect do their best to improve their conduct.

One by-product of the psychiatric point of view in social case-work is worth consideration in these days of overworked social workers, that is, the greater ease in work that it gives the social worker. The strain of dealing with unknown quantities is perhaps the greatest cause of fatigue in our work. The better we understand our cases the more readily and confidently we work. More exact knowledge of the personalities with which we are dealing, not only saves the worker worry and strain but also releases energy which can be applied to treatment. Besides, we know that the more our clients realize that we understand them the more we can do for them. Another result of understanding the natural causes of vexatious conditions is that impatience is almost entirely eliminated. No time is wasted upon annoyance or indignation with the uncooperative housewife, the persistent liar, the repeatedly delinquent girl. A small dose of reproof may be administered occasionally for therapeutic purposes, but as a rule no variety of impatience is of value in social treatment.

I have known social workers who looked with suspicion upon the careful preliminary study of personality, because they feared that all of the worker's interest might go into the analysis, and that treatment might be neglected. I believe this fear has been something of a bugaboo in social work. It is an unfortunate mistake to regard careful thinking as inconsistent with vigorous action. To be methodical is not to be mechanical; to be scientific is not to be less humane; to be thoughtful is not to be unfeeling.

These ideas are sometimes carelessly contrasted to the discouragement of better methods. We need more thinking in social casework. In medicine if the diagnosis is plain the treatment is usually clear. In social work if our analyses were more exact, the treatment would be more plainly indicated. We owe it to our clients to bring to bear upon their cases the best thought we can give and the most exact knowledge we can obtain.

It is now the generally accepted view that some knowledge of psychiatry should be part of the education of all social workers, and not confined as at present for the most part to social workers who deal with nervous and mental cases. This principle is now in operation in several schools of social work where a course in social psychiatry is required of all students. The future social worker, as I read the signs of the times, will have included in her professional education some knowledge of all the different branches of social work—psychiatric social work, medical social work, family rehabilitation, child welfare, community service. In three years of graduate work it would be possible to give instruction in all of these subjects with a year of practice in one or more fields. At present the need for workers in special fields is so pressing that we are forced to prepare students immediately for one or another type of work. Let us hope that it may not be many years before social workers will be required to have a broad general preparation comparable in content and discipline with training courses for other professions. Specialization afterwards is to be expected, according to individual aptitudes and interests. There will no doubt still be the psychiatric social worker whose purpose is to assist the psychiatrist in the care of mental cases and the investigation of mental disease. But the trained social worker of the future in all fields will know enough of social psychiatry to deal with the mental factors of social maladjustment.

MENTAL DISORDER CONSIDERED AS A PSYCHOLOGICAL REACTION.

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OF recent years psychiatrists have been turning their attention to the part played by mental factors in the causation of mental disorder. This field of investigation, however, is so extensive and has been so recently opened up that, notwithstanding the valuable work already done, it remains for the research worker practically virgin soil. There appear to be a great variety of mental causes from which a psychosis may develop and an understanding of these causes can only come from the study of a large number of cases. There is one principle, however, which applies in every case; that is, that the psychosis is the patient's reaction to some experience or series of experiences, to some situation in which he has been placed.

The causes which enter into the production of an abnormal type of mental reaction are of two kinds. On the one hand are the external causes, the more or less difficult situations which the individual may be unable to meet in a healthy way, and on the other hand, there are the internal causes, the defects in personality, the unwholesome tendencies which may lead him to react with a psychosis in situations which, to the ordinary individual, would present no serious difficulties whatever.

In no two cases are we likely to find that the situation or the psychosis to which it gives rise is exactly the same, although of course we do find certain general types of reaction which occur over and over again. The lack of uniformity in our cases is one of the things which makes it so difficult to draw conclusions in regard to them, for the conditions which give rise to the disturbance in one case are almost certain to be quite different from those which are found in the next.

In this article I shall present a rather simple case which shows one set of conditions out of which a mental disorder grew and which will serve to demonstrate the significance of the statement that a psychosis is a reaction to a situation.

The case is that of a young man who rather suddenly became moody and depressed and gave up work to spend his time in bed or lounging about the house. He indulged in violent outbursts during which he talked incoherently and behaved in an irrational manner, his condition finally becoming so serious that it was necessary to commit him to a hospital. To his family his depression seemed to have come upon him out of a clear sky; they knew of nothing which could have produced it. An intensive study of the case, however, made the cause of the trouble quite clear by bringing to light the situation to which he had reacted with a psychosis and the defects in his personality which had caused him to react in this way.

The patient was found to be rather above the average in intelligence. In public school he had always stood at the head of his class. He had been quiet and studious in his tastes and was inclined to be rather shy and retiring. At the same time, he had a high opinion of his own literary abilities and was very ambitious. He wished to obtain a college education and dreamed of ultimately taking up literature as a profession.

Unfortunately he was also weak and self-indulgent. He desired to accomplish great things but was not willing to exert himself or to sacrifice his comfort in order that his ambition might be realized. Whenever he had encountered any difficulty or unpleasantness, he had always reacted, not by putting forth extra effort to overcome the difficulty, but by becoming discouraged and seeking to exchange the difficult situation for an easier one. For example, after two years in High School, he became discouraged because he was not permitted to map out his own course, but was obliged to give a good deal of time to subjects which were not interesting to him. This caused him to leave school and take a position as an office boy. Later, he secured a position in a library where the work was of a kind well suited to his tastes and abilities, but he gave it up when he was obliged to work after closing time in order to have things in shape for the next day. On another occasion, when he was advanced from a simple routine clerical position where the work was easy, to another which gave better pay and opportunities for advancement, he asked to be moved back to his old job because in the new one the work was heavy and he frequently had to remain after hours to finish it.

Although this tendency to self-indulgence may be regarded as to some extent a part of his original mental endowment, there were certain factors which contributed to its development. Of these, one was the sheltered conditions under which he had been raised.

He was the youngest of several children and had always been petted and indulged by the older members of the family. If he had been obliged to fight his way through his difficulties, to stand on his own feet, he might have developed more sturdiness of character. As it was, being indulged in his tendency to avoid always what was hard or unpleasant, this tendency grew stronger as the years went by. Another factor was his unwholesome attitude toward his work. His ambition was to become a writer. He was interested in philosophy, science and literature. He cared nothing for business and regarded the various positions which he held as mere makeshifts. He did not feel that in these positions he was occupying his proper niche. He dreamed of some day getting into the kind of work for which he was fitted and there achieving a great success. For this reason, he did not take his work seriously. He did not regard it as important and his efforts to succeed in it were only half-hearted. So, whenever he found it hard or unpleasant, instead of looking at the difficulty as only an obstacle to be overcome, he regarded it as evidence that he was in the wrong kind of a job and his tendency was to give it up and seek another position to which he would be better suited.

In such a case as this, we see how the high ambitions which are supposed to be a spur to increased effort may sometimes prove only a handicap. If this young man had been possessed of more force of character, his ambition might have led him to study in his spare time. He might have attended evening classes. In fact, if he had shown a strong inclination to study, his brothers would have given him the financial support necessary to enable him to return to school and go on with his education. Thus he might have fitted himself for the professional career of which he dreamed and his ambition might have carried him on to success. But there was a weakness in his own character which prevented him from doing this. He, himself, was apparently conscious of it for he said, "My aim was high but I lacked the ammunition to drive me; my lack was not ability but simply driving force." So he drifted along in a desultory way and his ambition, instead of inspiring him to higher effort, merely prevented him from taking a healthy attitude toward the simple tasks which were close at hand.

Having considered the type of individual with which we have to deal, let us now consider the circumstances which precipitated his psychosis.

Previous to his psychosis he had been filling an easy but poorly paid routine clerical position. He had long been dissatisfied with his position and had repeatedly asked for promotion to something better. He was finally given the long wished-for promotion and was at first very much pleased with it. But he soon began to encounter difficulties in his new work. Perhaps his most serious difficulty was due to the fact that he was obliged to make out elaborate reports and statements. The data for these he had to obtain from the books of the various departments of the company in which he was employed. He had not sufficient familiarity with the bookkeeping methods in these departments to find the information for himself and, consequently, had to apply constantly to his fellow clerks for assistance and advice. He was shy and sensitive. He hated bothering people. Moreover, he felt that if he asked so frequently for assistance he would give the impression that he was not competent and was getting others to do his work. Therefore, when he had a report to get out which necessitated asking for information from people he had already been bothering a good deal, he would not have the courage to go to them. He would simply postpone getting out the report. Thus it was that, as the days went by, one neglected task after another piled up on him. He got farther and farther behind in his work and as the pile of neglected work grew larger he became more and more discouraged. He saw that he was not making a success of his new position. He knew that he could not hope to retain it unless he did better work. He went about daily with the dread hanging over him that his employers would discover how badly he was doing and that he would be severely reprimanded, perhaps discharged.

A man with any force of character, at this point, realizing into what a hopeless muddle his weakness and negligence had led him, would have pulled himself together, attacked the neglected reports and again gotten his affairs into good shape. But the patient was not such a man. As he, himself, said, he had lost heart and it had always been impossible for him to work at anything if his heart were not in it. It was quite characteristic of him that he should attribute his failure in this position, not so much to his own weakness as to the complicated system of bookkeeping which made it difficult to obtain the information required and to the fact that in any case the position was not one to which he was suited. So he simply marked time in his work, becoming every day more anxious and depressed. He would have given it up altogether, in spite of its opportunities for advancement, and have gone back to his old routine job, but another man was now filling the old place, thus cutting off that line of retreat. After a couple of weeks in his new position, he had his annual vacation and this afforded him a brief respite, a short two weeks, during which he was able almost to forget his troubles. But when his vacation was over and the morning came for him to return to work, he could hardly get himself out of bed and drag himself back to the office. Arrived there, he had no heart to attack the accumulation of tasks awaiting him; so he simply "loafed on the job," and "made a bluff at working"; then, after a few days, as the situation had become intolerable and as he felt that sooner or later he would be discharged in any case, he resigned his position, telling his employers that he was leaving the city.

By the time he gave up his position he had become very depressed. He had not only worried over the difficulties in his work and the fact that he was not making a success of it, but also over the possibility of having to give up his position and being unable to procure another. Having gotten into a depressed and anxious state of mind, he began to brood over things that previously had given him little concern. As he, himself, said, "One depression started another. Thinking about one thing started me thinking about something else. You can easily find things to worry about when you look for them." So it was that he began to brood over the fact that with all his fine ambitions he had been making nothing of his life, that his life in the past had been colorless, with few real pleasures and practically no friends. Being in this depressed state of mind, he had very little heart to go out and look for another position. Yielding, therefore, as always, to his inclinations, he spent most of his time at home either lying in bed or lounging about the house, not even taking the trouble to put on his clothes. He remained at home about five weeks, during which time he slept poorly, cried a good deal and at times worked himself up into an emotional condition in which he threatened to commit suicide, talked incoherently and "acted crazy." His crazy actions apparently consisted of gesticulating and throwing himself about in an emotional state that bordered on frenzy.

He now says that in acting and talking as he did he was only feigning insanity. He wanted to make the family realize how bad he felt. He evidently believed that he was telling the truth when he made this statement and it seems to have some basis in fact, for, although his behavior was undoubtedly an expression of genuine emotion, it is probable that he made but little effort for self-control, that, on the contrary, he endeavored to express his feelings as violently and extravagantly as possible. Two motives lay back of this. One was the demand for the sympathy which he hoped to arouse by his extravagant manifestations of distress. The other was a desire to justify himself in the eyes of his family for remaining at home idle, a burden for them to support. He himself felt that he was in a nervous and emotional state which rendered him unfit to go to work and he wished to make his family realize this by demonstrating to them what a bad condition he was really in.

Evidently he was at this time the victim of conflicting impulses and desires. On the one hand, there was his need for emotional outlet and the demand for sympathy and self-justification which impelled him to give way to the frenzied outbursts in which he talked and behaved in such an extravagant manner. On the other hand, he was impelled to inhibit these outbursts both from pride and from consideration for his family, for it was humiliating to be regarded as insane; moreover, he realized that by giving way to his emotions in this manner, he was bringing upon his family a great deal of anxiety and distress. The result was that his conflicting impulses swayed him now this way and now that. At times, actuated by one set of impulses, he would indulge in an emotional outburst, but later, when he heard members of his family discussing his condition, he would be ashamed and sorry and feel worse than before. Finally a physician was called in who said that his mind was affected and advised sending him to an institution. The patient was now feeling so ashamed and distressed by the fact that his family regarded him as crazy and by the trouble he had brought upon them, that the home situation had become intolerable. He therefore welcomed the doctor's suggestion as offering a way of escape from it. His own word's make his attitude in this matter fairly clear. He said, "My sister's children came around and saw me doing all sorts of queer actions. I knew what I was doing. But the poor children! I liked them and I always played with them and they thought their uncle was crazy and I felt ashamed of myself and I wanted to go away to Bellevue for about a week." At his own request, his brother took him to

Bellevue. When he expressed a desire to go to a hospital, he did not regard himself as really insane and did not think that he would be committed. He said, "I did not think they would regard me as insane. I thought I would be given good advice and allowed to return home after a few days. Instead of that, they treated me as an ordinary routine case of insanity."

From Bellevue he was committed to the Manhattan State Hospital, Psychiatric Institute Service. On admission, he discussed his case with the physician with a good deal of frankness. He was grateful for the advice which he received, but was not willing to remain in the hospital even for a short time and begged for his discharge as offering the only means of recovering from his depression. He was full of self-pity, bemoaned his folly in having asked to be taken to Bellevue, saying that if it had not been for this he would never have been brought here. He was continually appealing to the physician and to his relatives for sympathy. He spent a good deal of the time exercising his literary talent in the composition of letters to different members of his family which were calculated to work upon their feelings so that they would secure for him his speedy release. The following from one of his letters is fairly typical—"I am suffering indescribable agony and feel that my heart is actually breaking from having to stay among this class of people. . . . I am slowly but surely sinking into an unforeseen state. . . . Have me taken home, that sweet home, I never was away from it before."

He remained in the hospital for about six weeks, during which time he improved considerably, and was finally allowed to leave because his family were anxious to take him away.

Now this case affords a concrete example of what is meant by the statement that a psychosis is a reaction to some situation. In this case, it has been shown that the trouble commenced when the patient began shirking the difficult and unpleasant tasks in the new position to which he had been advanced, this being for him a characteristic type of faulty reaction as he had always been weak and self-indulgent. It has been shown how this led to his work's getting into a very unsatisfactory state, creating a situation to which he reacted by becoming anxious and depressed, finally giving up his position and remaining idle at home, brooding over his trouble and giving way to outbursts of emotion which were also appeals for sympathy and attempts at self-justification for his weak and self-indulgent behavior. And so on throughout the history of the case, it has been shown how his emotion, thought and conduct have been his reaction to the situation in which he was placed and how this reaction has been in keeping with the type of personality which he has always shown himself to be. The psychosis would seem at first sight to be something which had fallen upon the patient out of a clear sky. But, when we know the kind of a person he was, the experiences through which he had passed and the conflict that had been going on in his mind, we can see that his thought and conduct have been nothing more than what might have been expected from such a person under such circumstances; in other words, that his psychosis has been his reaction to the situation in which he was placed.

The case is a very simple and commonplace one; the forces to which the disorder is due have operated at a conscious level; there is no elaborate symbolism; but it is no less deserving of attention on that account. It is the commonplace type of case with which we most commonly have to deal and which, therefore, affords a most important problem in mental disease. Moreover, because it is very simple, it serves to demonstrate all the more clearly those fundamental principles of which, in the more complicated cases, it is so easy to lose sight.

One important principle to be kept in mind is that the pathological is always an outgrowth of the physiological. The key to the abnormal is always to be found in the normal. A very useful conception which psychology has given us concerning the normal mind is that it is a mechanism for producing useful reactions to the various situations in which the individual is placed. For example, when a man is placed in a position of danger, he will react with a feeling of fear and an impulse to escape, or when faced with some difficult situation, he will use his reasoning powers to discover the best way to deal with it. Now a psychosis may be a reaction of essentially the same type as that which occurs in a normal individual, only differing from it in the fact that it is a faulty one.

But why should we get faulty reactions? Why does not everyone react always in a normal way? There are probably various factors which go to determine the individual's reaction to a given situation, but of these the most important one is the mental make-up of the individual, the mental qualities with which nature has endowed him. No two minds are exactly alike nor can be expected to react to the same situation in exactly the same way.

Take the reactions of different men to the situation created by the entry of this country into the world war and the demand which it made upon them for military service. No other event perhaps has brought out so strikingly the different ways in which different individuals react to the same situation. One man reacts by rushing off to enlist, all eagerness and impatience to get into the fight. A second awaits the call to arms, hoping he will not have to go, but ready and willing if the call comes to make any sacrifice his country may require of him. A third whines and grovels and resorts to every device and subterfuge to escape being drafted, while a fourth reacts with such a profound emotional disturbance as to necessitate confinement in an institution.

The faulty types of reaction are only normal types wrongly used or carried to excess. Fear and the tendency to avoid personal danger constitute a useful type of reaction to certain situations, but they are out of place when a country is calling upon its men in the hour of need. The tendency to become discouraged and give up in the face of difficulty is a useful type of reaction when it prevents one wasting time and energy in attempts to accomplish the impossible, but it becomes a faulty type of reaction when, as in the case here presented, it is carried so far as to cause a man to give up his work whenever he encounters anything hard or unpleasant.

It is necessary in this connection to remember that a mental reaction, whether normal or abnormal, is not merely an act performed by the mind, but that it also involves a change in the mental state. This change may be chiefly emotional, as when on suffering some serious loss the mood changes to one of depression. It may be a change in one's mental attitude toward some person or thing as when, after receiving ill-treatment at the hands of some person, the attitude toward him becomes one of antagonism and dislike. Or again, it may consist of the development of new beliefs or the modification of old ones as the result of experiences through which one had passed. When we speak of a psychosis as a mental reaction to a situation, we have in mind, not so much the behavior with which the individual has reacted to this situation, as the underlying change which has taken place in his mind; for example, the depression which has resulted or the false beliefs which have been developed.

But if we get the same types of reaction in both normal and abnormal mental process, what is the difference between them?

What distinguishes the normal from the abnormal? As a matter of fact, there is no sharp dividing line. No one can say where the one ends and the other begins. There are a large number of borderline cases where it is doubtful whether the reaction should be classed as merely an unhealthy one, or whether it should be regarded as a psychosis. For example, in the case here described, the patient's reaction does not differ very much from those forms of thought and conduct which we see in presumably normal individuals. To become depressed and to give up in the face of difficulty, to yield to outbursts of emotion, these are reactions we have all indulged in to a greater or less degree. It is only when, as in the present case, these reactions are carried to such an extent as to render the individual unfit to fill his appointed place in society, that they are to be regarded as abnormal.

In conclusion, I would like to point out that, since the psychogenic disorders are simply the reactions of human beings to situations in which they are placed, we can easily see why they present such an infinite variety in their clinical pictures and why they are so hard to classify. Every psychosis is a product which results from a certain type of personality reacting to a certain situation, but as in no two cases is either the situation or the personality quite the same, so in no two cases can we expect to find exactly the same kind of psychosis resulting. To be sure there are certain general types of abnormal mental reaction to which our cases conform in a greater or less degree, just as there are general types of normal reaction, and it is not unlikely that, when we have acquired a fuller knowledge of these fundamental reaction types, they will form the basis of a better system of classification than any we have at present. But no matter what system of classification we may adopt, we need never expect to find any definite lines of cleavage dividing our cases into distinct groups, any more than we need expect to find a definite line of demarcation separating the abnormal from the normal.

MENTAL DISEASE IN FAMILIES

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THE classical doctrine on the transmission of mental disease is that of the French school and notably that of Esquirol and Morel. This doctrine affirms that all forms of mental disease and a large number of nervous disorders together with some constitutional states are various and interchangeable manifestations of hereditary degeneracy. Thus, the doctrine assumes that such varied diseases as idiocy, cretinism, moral insanity, hebephrenia, catatonia, mania, melancholia, involution and senile diseases, neurasthenia, hysteria, epilepsy, criminality, and eccentricity in all its thousand and one forms, are not really separate conditions but merely manifestations of one condition: to wit, inherited and inheritable degeneracy. Some French writers have even included in this group tuberculosis, alcoholism, and rheumatism. The French doctrine holds that the lighter forms of degeneracy appear in the first generation as eccentricity in its protean forms of "self-centered narrow-mindedness, fanaticism, spiritism, and unwholesome contempt for traditional objects, anti-crusades of all kinds, miserliness, spendthrift ways" or neurasthenia and the related diseases. In the second generation the nervous disorders are more accentuated—severe hysteria or epilepsy or periodic psychoses with more marked disturbances and true paranoia. In the third generation there are more severe psychoses which start earlier and end in profound dementia. The fourth generation sees the ending because the idiots, hebephrenics, etc., who comprise it, cannot propagate.

Most eminent psychiatrists have, at least in part, approved this theory of degeneracy. The French have practically all accepted it and the English generally. In Germany there is a division, but nearly all the older psychiatrists, for example, Griesinger, Schule, Krafft-Ebing, Ziehen, Möbius (who very trenchantly calls neurasthenia the "primeval ooze" of all degeneracy), Kraepelin (in his earlier writings), Bumke, Liepman, Binswanger, etc., give their approval. There is to be noted, however, another less well known group of German workers who have tried to show by actual clinical studies of families in mental hospitals that family mental disease runs in groups of mental disorders which are related and which exclude other groups. Thus Sioli and Vorster declare that manic and dementia praecox exclude one another in heredity, to which Kriechgrauer gives assent. Less extreme than these, Jolly, Albrecht and Pilcz find that dissimilar heredity exists, but that the main trend is toward similar heredity and assume for the dissimilar a *Keimschaden*, that is, germ-plasm injury which is not a true heredity but, in a sense, congenital disease.

In America the question of polymorphism has scarcely been considered. So far as the writer knows, Rosanoff and Knapp are the only workers who have studied it, although practically every hospital history taken in America assumes it, since no attempt is made to differentiate the type of mental disease in the heredity. But with a few notable exceptions the specific problems have not received research attention. Davenport and his co-workers and Rosanoff and his have contributed the most to the subject—Davenport to the question of feeblemindedness and epilepsy and Rosanoff to clinical psychiatry. These two writers have worked entirely from the standpoint of Mendelism and their efforts seem to me to be directed not so much to discover the laws of the transmission of mental disease as to fit the facts to Mendelian theory. To do this with any show of plausibility it has been necessary to divide mankind into two types—the normal and the neuropathic. It is assumed that the neuropathic differ from the normal by the lack of some normal determiner. There is no evidence brought forward to substantiate this view and it is just as reasonable to assume that a diseased or new determiner is at work. Moreover, it is premature, to say the least, to assert that all the different forms of mental abnormality (feeblemindedness, epilepsy, criminality, etc.) are related to a unit determiner, or group of determiners, for the laws of Mendel have not been shown to apply for any single normal human character of simple type, except perhaps eye color. As we know that normality is an *abstraction* rather than an *entity* it is at present presumptous to relate all changing forms of normality to a unit group. Furthermore, I question whether a true Mendelism hås been followed. The dominant characters of Mendel appear in a first generation through the mixing of two stocks, and in the second and later generations the proportion of recessive and dominant appears through the inbreeding of the first generation; that is to say, what would correspond to the mating of brothers and sisters in human relationships. No such conditions prevail in mankind, and expectations of ratios and proportions seem futile.

As a contribution to the question of the heredity of mental disease a study was undertaken of the families represented at the Taunton State Hospital. Realizing that some of the descendants of patients become themselves patients, but that *the great majority do not*, we had hoped to be able to study the questions: What happens to these last, that is, those descendants of patients who disappear into society? What is their fate? Do they give evidence of a progressive degeneration or of a regeneration, or of both? How do they succeed in life? In how far do they contribute to society's problems—mental disease, criminality, feeblemindedness, pauperism, disease? Since lack of financial assistance made the study of these larger questions impossible, the problem was attacked for the time being along simpler lines.

The Taunton State Hospital was opened in 1854. A survey of the record of patients shows that from 1854 to January, 1916, there were 22,300 admissions to the hospital. From a rough calculation made by analyzing 3,000 records taken at various points in the history of the hospital, it seems that about 16,000 persons are represented in the 22,300 admissions. Of the 1,300 patients in the hospital at the time the survey was made, roughly 10 per cent were related to one another. Of the patients that had been in the hospital from 1854 to 1916, there were 1,547 who were related to one another and these represented 663 families. The records of these related patients were analyzed, field work was done in a great many instances and all the patients then in the hospital were re-examined and interviewed. It is realized, of course, that because of changing psychiatric viewpoints, of differences existing in individual records and of the liability of error and misstatement in personal opinion as to diagnosis of mental cases, the use of the old and even of the new records is unsatisfactory. Still, it was possible to obtain from such a study a considerable body of fact that is significant in its bearing on present and past theory of the heredity or transmission of mental disease, on the social relationship of the insane, and on the proper plan and method for further study of the transmission of mental disease. A full report of the data obtained, together with family histories and individual case studies, has been made elsewhere.*

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* Psychiatric Family Studies. By Abraham Myerson. *American Journal of Insanity*, vol. 73: p. 355–486, January 1917; and vol. 74: p. 497–554, April 1918.

In order to make the results more easily accessible for consideration and criticism there is here presented only an outline of such tentative conclusions as seemed warranted by the data.

It is to be emphasized that the results presented, though fragmentary in their bearing upon the transmission of mental disease, have the merit of being based on hospital cases, studied and recorded by hospital men. The fundamental effort has not been to produce a theory of the inheritance of insanity, which in my opinion is at present a futile matter, but to make predictable, family mental disease. The problem may be formulated by two questions:

1. Given an insane parent with a definite type of mental disease, *if he has insane descendants*, what type of mental disease may we expect in those descendants? (It is emphasized that he *need not have* any insane descendants just as normal people *may have* insane descendants.) This question concerns what I have called the vertical aspect of mental disease, that is, its change from generation to generation.

2. Given an insane person with a definite type of mental disease, if he has insane brothers or sisters, what type of mental disease may we expect in those brothers and sisters? Here again it is emphasized that these insane persons' fraternity may be entirely normal. This question is the horizontal aspect of mental disease.

The answers to these two questions will be considered, but it may be of interest to take up first a few related points.

THE NEUROPATHIC HEREDITY OF THE INSANE AND NON-INSANE

This question has not been personally studied. The conclusions here stated are taken from the only two important studies on the subject, those of Koller and Diem. A few of their data are to my mind clear-cut enough to be important.

1. There is very much general neuropathic heredity in the direct and collateral relatives of both the insane and sane.

2. There is far more insanity in the families of the insane, and this is especially true of the parents and grandparents of the insane.

3. Insane uncles and aunts occur about as frequently in the families of the sane as in those of the insane; therefore, collateral insanity is of relatively little importance unless associated with parental insanity.

4. The sane seem to have as much, or even more, of nervous

disease, senile dementia and apoplexy in their ancestry. This would throw out of court as useless, the questions as to nervous disease, apoplexy, etc., in insane hospital histories. It would entirely vitiate the value of such works as Davenport, in which apoplexy is considered a neuropathic taint when, as a matter of fact, the question is entirely arterio-cardio-renal.

MARRIAGE RATE OF THE INSANE

In the four groups studied personally, including males and females,—alcoholic insanities, general paresis, dementia praecox, and senile dementia—we find first, that the males in the alcoholic, paretic, and dementia-praecox groups marry less than do the females. In the seniles, although the percentage of married men is greater, the totals of those who have entered conjugal relations at one time or another are about equal. Looking somewhat closer, it is found that in paresis there is only a slight difference in favor of the female, while in dementia praecox this difference is much further increased; thus, if these groups may be held to constitute a menace by virtue of their ability to transmit the psychotic taint to another generation, the female of the species, to use a well known phrase, is more dangerous than the male.

The seniles and the general paretics marry but slightly less than do the same age-groups in the total population; the alcoholics show a decided falling off as compared with the total population; while the male dementia praecox has an exceedingly low marriage rate. That is, *whatever is back of dementia praecox, it operates against self-perpetuation*. Something of the same internal mechanism is seen in the case of alcoholism. This mechanism operates very little, if at all, in the case of paresis and the senile psychoses. One might conclude that if there is an inborn defect in these diseases it is by far greatest in dementia praecox, is next in alcoholic insanity, and least of all in syphilis and the senile psychoses.

We are shown that marriage acts as a barrier to the propagation of the abnormal in so far as this is connected with endogenous factors. It is not a barrier against certain of the exogenous race poisons, such as, for example, syphilis, at least in that form which leads to paresis. We need to strengthen the barrier against the endogenous diseases, as for example, dementia praecox, but not nearly so much as we need to strengthen it against the exogenous, as, for example, syphilis.

GENERAL STATISTICS

For the purpose of comparison, figures obtained by Mott in his studies have been included in the following summary.

1. More females than males are concerned in family psychoses. The studies at the Taunton State Hospital showed 808 females and 739 males.

2. The mother-daughter group is much more common than the father-daughter group—80 to 59, as shown by the Taunton figures; 137 to 103, as shown by Mott's figures.

3. The mother-son groups are about equal.

4. Mother-son and father-son are about even—56 to 59, in accordance with Taunton figures; 96 to 88, as shown by Mott's figures.

5. Sisters alone decidedly outnumber brothers alone—80 to 57 according to Taunton figures; 211 to 140, according to Mott's figures.

If insane women transmit their mental peculiarities to their female children more than they do to their male, then the greater marriage rate amongst insane women may decidedly play a part in determining the preponderance of insane women. Furthermore, men migrate more than women, and so in any given hospital district the female descendants of insane ancestors would be more apt to appear in the asylum than the male descendants even if given equal rate of incidence. That is to say, a larger part of these men would end in jails or in hospitals in districts remote from their former home, etc.

ANTICIPATION OR ANTEDATING

This term is used (Darwin) to describe the earlier appearance of mental disease in the younger as compared with the older generation. This phenomenon has been given great prominence by Mott and his co-workers. He regards it as an effort of nature to get rid of the disease by crystallizing it in a few descendants and making them more easily vulnerable or unfitted to propagate by being brought early to hospitals. There are thus in Mott's definition of anticipation, first, a crystallization of the insane elements leaving other descendants free from disease, and second, earlier onset of the psychosis in the affected members.

All of the figures, and especially in the second generation cases, seem to point clearly to the validity of the phenomenon of antedating or anticipation. A closer examination, however, shows one great fallacy underlying the statistics and that is, as usual, the method of collection. In a majority of cases the period of time during which the cases have collected is not clear (for example, in Mott's statistics where no mention is made of the period during which his figures have been collected), but it is generally within 30 years. As the average ancestor is at least that much older than his average descendant, it would be practically impossible for the descendant to be older than the ancestor at time of commitment, and the age difference between ancestor and descendant would generally be from 33 years to zero, in favor of the ancestor, and in certain cases where the descendant enters the hospital before the ancestor it would be 30 years or more. This means that in the cases of some of the investigators it has been possible for the younger descendants to enter the hospital, but time enough has not elapsed for the older descendants to arrive. As the Taunton figures have been collected since 1854, this objection does not obtain with such force. Nevertheless, the rate of commitment has increased within the last generation, so that even in my cases the bulk of families has arrived within the last 30 years and thus the factor stated above still plays its part in falsifying the manifest results.

It is probable, therefore, when all is said and done, that in a very large proportion of cases the descendants of the insane who themselves become insane do so at an earlier age than their ancestors. Moreover, as is well known, these descendants have a much lessened chance for marriage and so this factor of anticipation seems to be, as Mott believes, a potent factor for race regeneration through elimination. One need not, of course, subscribe to any such anthropomorphic absurdity as that nature has any intentions in the matter. It is perhaps better to speak of this phenomenon as the downward trend of psychiatric families just as the sane descendants represent their upward trend.

TRANSMISSION OF INSANITY

With reference to the vertical aspect of insanity:

1. Given a paranoid type of psychosis, including in this term true paranoia, paranoid dementia praecox and unclassified paranoid states, what types of mental disease may we expect in the descendants? The answer is definitely that we may expect either paranoid disease or ordinary dementia praecox in the insane descendants, and this statement is corroborated by Jolly, Luther,

Krueger, Rosanoff and Albrecht. Practically no manic-depressive descendants appear.

2. Given well defined dementia praecox in an ancestor, what type of mental disease may we expect in the descendant? Dementia praecox follows in the large majority of cases. Feeblemindedness of a type which is perhaps very early dementia praecox is relatively common. Epilepsy is noted. Manic-depressive insanity occurs very rarely if at all.

3. Given a well defined manic-depressive insanity in an ancestor, what type of mental disease may we expect in the descendants? There appear to be two main trends, one towards manic-depressive insanity and the other towards dementia praecox. Difficulties in diagnosis play a large part in solving this particular question, but it is certain that short attacks of mental disease bearing the earmarks of manic-depressive in an ancestor are followed in insane descendants by a definite dementing psychosis corresponding to what this uncertain generation calls dementia praecox.

4. Given an ancestor with involution psychosis, what type of mental disease may we expect in the insane descendant? It seems to be universal experience that dementia praecox follows involution psychosis and that apparently no matter what the type of the involutional insanity.

5. Given an ancestor with senile psychosis, what type of mental disease may we expect in the insane descendant? The Taunton figures, as well as those of Vorster, Albrecht, Jolly, Luther and Krueger, all find that what is termed "senile dementia" is of such heterogeneous nature that what might be expected, occurs; that is, dementia praecox, manic-depressive, paranoid psychoses, imbecility and epilepsy, all are found in the insane descendants.*

If then, we survey the facts which have here been presented together with the trends observed in the literature, we find that the paranoid and catatonic diseases trend finally to dementia praecox; that manic is succeeded by manic and in a varying proportion of cases by dementia praecox; that the senile and involutional psychoses, if paranoid, or more properly involutional and senile, trend towards paranoid diseases and dementia praecox. Manic states of the senium follow the rule of manic states elsewhere. Neither for organic brain disease nor alcoholic psychoses can anything very definite be said, except that in the cases studied, wherever adequate history has been obtained, the psychosis in the descendant of the alcoholic or of the patient with organic brain disease can be related to some other more definite psychopathic feature than either alcoholism or organic brain disease. *It will thus be seen that all roads seem to lead to dementia praecox and from thence to imbecility.*

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* Op. cit., page 480, gives a fuller discussion of the senile psychoses.

With regard to the horizontal transmission of insanity, it may be thus restated: Given an insane person, what psychosis may we expect in his insane brothers or sisters?

1. The psychoses of brothers and sisters tend on the whole to be of similar type.
2. If one brother or sister has dementia praecox, the chances for dementia praecox in any other insane brother or sister is very great. Feeblemindedness, or what is called feeblemindedness, occurs frequently. This, as has been before stated, may merely be congenital dementia praecox with dementia as the leading feature.
3. Manic-depressive insanity and dementia praecox are said to occur together in the same family group of brothers and sisters. Such cases are usually atypical, and really clear-cut cases with such association are rare.

OTHER ASSOCIATIONS OF INSANITY

With reference to the relationship between insanity and genius, it may be stated in answer to the question, how far is genius related to insanity, that the Taunton families would indicate that it is not directly related, for no genius and no high-grade talent of any kind has appeared prominently in any of the family groups studied, despite the fact that the district is the one in which the earlier settlers of the United States first appeared and from which many of their talented descendants have spread throughout the country. It is, of course, true that many geniuses have been insane. It is also true that the world has very largely followed insane persons and has mistaken their insanity for genius. It is probably true that insanity tends more to low-grade mentality and feeblemindedness than it does to genius and talent.

An interesting matter is the relation of tuberculosis to insanity. We have the statement of Heron that tuberculosis and insanity are closely related, a conclusion he has reached through a statistical study. This is, in a sense, an accepted conclusion, since most hospital historians usually inquire into the incidence of tuberculosis in families. My own records and charts show it to be very common amongst the fraternity, etc., of the insane and quite frequent in their ancestors.* Nevertheless, since tuberculosis is the most common of diseases, one should be careful not to mistake coincidence for a closer relationship. Certain facts show that its spread is by no means coincident with the spread of mental disease. The white plague has a very disproportionate incidence amongst the poor, whereas insanity shows no such tremendous predilection for poverty. Tuberculosis kills in the early years of life, whereas mental disease gains in frequency in the later decades. Racial stocks particularly prone to tuberculosis, for example, the American-Irish, show no greater amount of insanity if as great as stocks with very much less tuberculosis; for example, the American-Jewish. It is very likely that the insane, their fraternity, ancestors, and descendants are more apt to live in social conditions predisposing to tuberculosis than are the non-insane.

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* Op. cit., families 2, 11, 19, 25, 29, 37, 43, 66, 70, 83.

Criminality in the families here studied has been a very inconspicuous feature. It is true that certain of these insane have committed crimes while insane. That, however, does not make them criminals, since the crime was brought about by insane delusions, etc. Criminal relatives either in the fore or after generations have been infrequent. This may be due to the social conditions of this community. It is my belief, apart from facts which can be demonstrated in this study, that criminality stands in closer relationship to forms of feeblemindedness and alcoholism than it does to insanity. This, however, is certainly a matter which cannot be settled by insane hospital cases.

CONCLUSION

It may be stated again that we are not ready for any theories of heredity in the psychoses, for the fundamental reason that we have not reached a resting point either in our knowledge of the psychoses or in our knowledge of heredity as applied to man. It may well be that the psychoses represent disease processes rather than true heredity. It may be that they represent abnormal variations unfitted for survival in the world as it is at present organized, and that insanity in some of its phases is merely an excessive variation along well marked character lines, that it is a disease or abnormality merely by excess of variation rather than by defect of any character. What needs to be done is the establishment of an organized research carried along several definite lines, for example:

1. The study of the descendants of syphilitics, whether those syphilitics have been insane or sane, or have had neurosyphilis or not.
2. The study of the descendants of alcoholics.
3. The study of the descendants, normal and otherwise, of the insane confined in hospitals.

HOW TO AVOID SPOILING THE CHILD*

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I AM going to say a little about the way the mind develops in human beings and in higher animals.

Biologically, the human being, like other higher animals, and lower animals, too, for that matter, is an organism striving toward certain ends. An organism is, biologically, something that strives to maintain its own life and to perpetuate and increase the life of its race, and the evidence of that striving is what we call the behavior of the organism. Behavior is the pursuit by living things of their own welfare and their own ends and purposes; it is the manifestation of striving toward ends.

We are conscious ourselves of our movements; our own behavior is associated with something that we call "mental," which goes on inside of us, and we come to the conclusion, on watching the behavior of other people, that they also must have something "mental" or "psychic" going on within them that is more or less like what goes on within us. So what we know about mind is based upon a study of our own behavior and its psychic concomitants and upon the study of the behavior of other people. We look into ourselves to see what happens in us when we behave, and we draw inferences regarding what happens inside other people when they exhibit behavior.

Through the work of the comparative psychologists we have learned much about the innate disposition of living animal organisms; the innate traits of mind, the things upon which behavior depends. The so-called instincts have at least three sides to them; they involve not only (1) impulses toward gaining the ends that the instincts subserve, but also (2) feelings, or sensation, of being affected, at the same time, and also (3) cognitions. To use McDougall's terms, in the exercise of an instinct there is "a knowing, a feeling and a striving."

I may mention a few of the more common instincts, well known to everyone: (1) the nutritive instinct, associated with the feeling of hunger and the impulse to take food; (2) the motor instinct, in young children to crawl and to walk; (3) the instinct of flight, when we recognize that we are in an unfamiliar situation or in danger; it is associated with the emotion of fear, and with a tendency to flee or hide; (4) the instinct of repulsion; for instance, if we taste something bad in our food it excites disgust; (5) the instinct of curiosity, where we see something similar to something we have seen before, and yet a little different from it; this makes us wonder and we have the impulse to approach it cautiously and to examine it to see what it is like; (6) the instinct of pugnacity, that comes into play whenever our impulses are opposed in any way; we are excited to anger and we try to remove the obstacle, or, if we cannot remove it, we try to destroy it; (7) the instinct of self-abasement, which becomes active when we see people whom we think may be superior to us; we often have a feeling of submission or of subjection to them, and we try to make ourselves less obvious and may even slink away and try to hide ourselves; just the opposite occurs with (8) the instinct of self-assertion, when we are in the presence of spectators whom we think may be inferior to us; we tend then to have a feeling of elation, of well-being, and an impulse to boast; (9) the parental instinct, which is excited at the sight of a child, or the sight of weakness; thus, to see cruelty inflicted on the weak excites in us a tender emotion and the impulse to protect, to cherish, to help; (10) the sexual instinct, which is concerned when the sight of one of the opposite sex (under certain circumstances) excites the feeling of lust and the impulse to approach, to fondle and to embrace; I might mention also (11) the instinct of acquisition, and (12) the instinct of construction; and there are probably still others. These are at least some of the instincts that the comparative psychologists have studied and made us familiar with. They are the innate traits with which all begin life, and our higher mental qualities and our total behavior are built upon the basis of these simple fundamental instincts. Gradually, through multitudinous knowings, or cognitions, we acquire a body of "knowledge," and through multitudinous feelings and strivings we acquire what we call "character." Knowledge and character are built up out of the workings of the simple instincts.

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* Remarks made at the 112th annual meeting of the Medical Society of the State of New York. Acknowledgment should be made of our indebtedness to the editor of the *New York State Journal of Medicine* for permission to reprint this article, which was originally published in the March, 1919, number of the *Journal*.

A word as to the nature of the "sentiments." These are very complex things; they represent associations of cognitions, with feelings and strivings. In other words, sentiments are complex feelings related to certain objects; we "love" certain things and we "hate" certain other things. For instance, the love of a child is a sentiment; the love of virtue is a sentiment; a love of power is a sentiment; the love of a church, the love of America and the love of the American flag are sentiments. We gradually develop also sentiments of hate. We learn to hate dirt; we learn to hate vice; we learn to hate disorder, and in this war we learned to hate German militarism.

Most important, perhaps, for social life is the development of what has been called the self-regarding sentiment—what is known as self-respect; this is not merely pride or self-love in the narrow sense. Self-respect is based largely upon a combination of the activities of two instincts, that of self-assertion on the one hand and that of self-abasement on the other. It includes the disposition of "negative self-feeling," and also that of "positive self-feeling." This self-regarding sentiment has had much to do with the origin and maintenance of social customs and with the development of the higher kind of conduct of human beings.

Obviously among so many tendencies and impulses there must be a tendency to conflict, and unless we learn how to organize the lower instincts into sentiments and to organize the sentiments into well-directed aims and purposes in life, we shall have mental conflicts and loose, dissociated personalities. It is very necessary that the instincts and the sentiments should be organized into a unified mental life.

The education of a child, then, includes education in self-expression and education in self-control. A certain amount of repression of the impulses is necessary. The child must learn properly to repress, and the reasons for this. Of course, there are very bad forms of repression as well as good forms of repression. Doctor Healy will perhaps tell you that it is essential that each one learn how to repress in a proper way in order that he may not have a chaotic life.

As McDougall has well said, there are four levels of conduct; (1) the level of instinctive behavior, modified by pains and pleasures incidentally experienced; (2) the level of behavior that is modified by rewards and punishments in the social environment; (3) the level of behavior that is modified by anticipation of social praise and blame, and (4) the level of the highest kind of conduct, in which behavior is regulated by an ideal of conduct, the person learning to do what seems to him right regardless of the praise or blame of his immediate social environment.

Behavior will obviously be dependent (1) upon the kind of instinctive foundation we possess—our hereditary traits, and (2) upon the environment to which the nervous system and the organism as a whole is exposed. What we inherit from our ancestors and the influence of things outside us after we begin to develop are the two great underlying factors of behavior. Heredity plays a very important part, just as environment does. There should be no quarrel between the advocates of the importance of heredity and the advocates of the importance of environment, for both are very important. There is no sense, it seems to me, in minimizing the importance either of heredity or of environment. At present it is true we can do more to modify environment than to modify heredity. But let us recognize the fact that heredity is equally important with environment in the development of organisms and their behavior and look forward to a future when we may wisely subject both factors to suitable control.

There can be no doubt that many of the psychopathic children, and many of the mental defectives that we see, are due to hereditary factors rather than to environmental factors. Thus, if two imbeciles marry, in the majority of cases all of their children will be imbeciles. Again, we all know how melancholia and mania tend to run in families; there is no doubt that the tendency to the manic-depressive psychosis can be inherited. Epilepsy is an exquisitely hereditary disease. I am not sure but that the tendency to some forms of delinquency may be inheritable.

The environment, it must be remembered, however, affects not only the ill-born, but also the well-born. At this meeting today we are more directly interested in the study of environment, (1) on the physical side, (2) on the psychic side and (3) on the social side.

On the physical side the importance of properly nourishing children, housing them, clothing them, resting them, exercising them, protecting them from infection, are all obvious to every one —to the laity as well as to physicians. On the psychic and social sides, however, people are not fully awake, I believe, to the importance of the problems that confront them, though they are becoming awakened by meetings of the kind we are now attending.

On the psychic and social sides of the development of the child, the family and the servants in the family come first into consideration. Then come, I think, the neighbors, the neighboring children especially; then the school, then the church and other associations into which the child enters. Then there are books, plays, moving-picture shows, theatres and things of that sort to be borne in mind. I put the family first because I believe that is the most important factor, and it is in its influence that most mistakes, perhaps, are made, and in it much can be done to improve conditions.

The study of the normal family becomes ever more interesting to sociologists and to social workers. I do not know how many of you have read the recent article by Margaret F. Byington on this subject, but it is a valuable and readable paper. Any of you who haven't read it would, I feel sure, enjoy looking over it. In it she points out how in recent times the conditions of the family have changed, especially regarding the economic cooperation of the family. Formerly, every member of the family had to be cooperative in the family as an economic unit, but now the economic side is less prominent and the main characteristics of the environmental influence of the normal family are cultural, educative and disciplinary. In my own opinion the family is the chief place for the cultivation of adequate personal expression, for teaching the proper control of impulses and for favoring the growth of the higher sentiments and ideals. It is the place for the organization of the primitive instincts into higher psychic units. It is, and should be, the family in which the child becomes initiated by example, by precept and by opportunity into the social life of his time.

Now, in the family, both the mothering and the fathering are important. Let an institution do what it will, be it as good as this* is, there is something that comes from the emotional side of family life that is impossible to get in an institution where the children are not in contact with and under the influence of their fathers and mothers. This contact and this influence are not replaceable, so the family is a better place to grow up in than an institution, provided the family is a normal family. But when the family is abnormal, then it may be important, and often is very important, to transfer the child to an institution.

The habits of the child, the interests of the child and the ideals of the child, are gradually developed in the normal family. There may have to be sometimes a little physical punishment very early. In a normal family I should think that perhaps one salutary spanking was enough. I have observed instances in which one spanking during the first two years—not afterwards—was administered and seemed helpful. With a normal child, after that one spanking has been given, it is rarely necessary, provided there be consistency and good sense in the management on the part of the father and mother, to resort to further physical punishment. Rewards and punishments of other sorts, especially judicious praise and very occasionally pedagogic blame, are useful as agents to modify a child's behavior.

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* The New York State Training School for Girls, at Hudson, New York, in which the meeting was held.

The child's allowance chart* is a helpful means, I believe, in making the child learn to govern itself. After a child reaches the age of six or eight it is often irksome to the parents to be saying, and hard on the child to be hearing, "Don't do so and so." In the allowance chart there is a list of twelve or fifteen things to which the child needs to pay attention; for instance, getting down to breakfast on time, having its hands washed before dinner, observing punctually the study periods, and keeping its desk in order; there are a number of little things that every mother has to make sure that the child does. In the allowance chart the child is allowed a certain number of marks for each one of these duties faithfully performed during each day. At the end of the week, if the child's allowance is 50 cents per week, and he has got only 50 per cent of the marks that are given for full performance of his tasks, he will receive only 25 cents. I have seen this tried in a number of families with remarkably good results. The children keep the chart themselves and thus learn to govern themselves. They have to be children of the better sort, perhaps, to do this, but the use of this method often relieves the father and mother of much detail of personal supervision. After a child has kept such a chart for a few months it can often be dispensed with. The children I have observed have been honest and conscientious in recording their marks.

A word as to caprices of children regarding diet. As a practitioner of medicine I have found that no small part of the troubles of patients about eating in later life, dates back to the mistakes of childhood training, when parents permitted caprice. Parents should know what is a good diet for the child, should place the food before him and should see that he eats it. Parents are often responsible by being capricious about food themselves. A parent's bad example may be very harmful to the child. Parents should set the example of eating all kinds of simple foods regardless of choice, and no child's likes and dislikes in regard to diet, except in rare instances of undoubted idiosyncrasy, should be very much heeded.

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* Obtainable from Rowland and Ives, 225 Fifth Avenue, New York City.

And now a word as to regular bathing. Many children hate to take a bath, but if the parents bathe daily themselves, and teach their children in early life to bathe daily as a regular habit, these children as they grow up look upon the daily bath as a most natural habit, and expect nothing else. The same applies to exercise and to proper dress. The child should have regular hours for exercise in the open air and the parents should make proper provisions for this and make sure that it is made enjoyable. Children should also have regular supplies of simple, sensible, clean, attractive clothing, and should be required to wear what is supplied.

The general physical and psychic hardening of children is another important matter. Many children, especially nervous children, are oversensitive. Much can be done to help by a judicious hardening process. Common sense, of course, is necessary, for it is harmful to take a child that is oversensitive and be too hard with it. Parents, especially among the well-to-do, are prone to err on the side of indulgence rather than on the side of overhardship. They are often not firm enough with children in regard to the maintenance of a normal routine, allowing their children to break through it too easily. When parents are in doubt as to the course they should pursue they should seek the advice of the family physician.

In educating the children to self-control, and especially to control of temper, parents can do a great deal. Many parents allow children to give way to emotional outbreaks. If a child cries for something hard enough the foolish parent will often give it what it wants. This is, of course, a disastrous policy to pursue. I once knew a girl in a large American city who boasted that she could make her father give her a Packard automobile just by going into a tantrum, and she did. She had found out that she could get anything she wanted if she made enough fuss about it. Rewarding emotional outbreaks in such a way is very injurious to a child. A child should be taught that it can more often secure things that it desires by controlling itself, than by losing control. It is self-control that should be rewarded, not the evidences of lack of control.

If a little child, for instance, crying because it wants something very much, be taught to stop crying, and to say, "Please, may I have that?" before it is permitted to have it, it will learn that self-control, rather than the lack of control, has brought the reward.

Consistency in policy and attitude on the part of the parents is essential if a child is not to be misled and confused. How often one hears a mother tell a child to do something, and then observes that this mother's own attention becomes distracted, so that she allows the child to do something else, to the neglect of carrying out the order given. If in early childhood an order be once given, one should see to it not only that it is obeyed, but also that there is prompt obedience. Again, a mother should not follow one policy one day and another the next. Such inconsistency can be very harmful to the developing child. For the same reason, the father and mother should agree on the course to be followed and should make sure that they support each other in it. To develop any stability in a child one must be consistent in the demands made of it.

Then comes the example of cheerfulness and of good will. Parents who give way to their own depression before children may do them a vast deal of harm. Parents who indulge in fault finding, and who impugn the motives of others before children, set a bad example. Parents who indulge in personal gossip before their children exert an influence that may lead their children to the pernicious habit. Parents who complain of their own ills, such as their headaches, their pains and their lack of appetite, before the children, may plant the seeds of hypochondriasis in the minds of the children. A mother ought to be ashamed to admit to her child that she has a headache, for during this early period there is great danger of "psychic contagion." Much that has been attributed to heredity is really due to psychic contagion in childhood. Many people develop "habit headaches" and "habit pains," and unwillingly encourage the development, by imitation, of similar headaches or pains in their children. Everyone should learn to "consume his own smoke." We help other people to keep well if we ourselves give the impression of feeling well and cheerful. Here, if anywhere, is the place to assume a virtue if you have it not.

A child should never be permitted to use invented physical symptoms or nervous symptoms to escape from its duties. Many a child learns that he can stay home from school, or from Sunday school, or from dancing school, by having a headache. Children, as well as grown-ups, are tempted to invent some excuse in the hope that they may escape duties or occupations that are a little unpleasant or irksome to them at the time. The wise parent should see to it when the child says he has a headache and is permitted to escape some normal function, or some duty, on account of it, that he does not have too good a time. Let him stay in bed with restricted diet, restricted companionship and restricted activities until the headache is better, and then if he has been fabricating his headaches he will not have them so often.

Good teamwork on the part of the parents is, as I have said, very important. Sometimes the father will undo all the mother does in the way of discipline, and sometimes the mother will undo all that the father has tried to do. Nevertheless, it is most desirable that the child grow up under the influence of two parents. The fatherless child is to be pitied, just as the motherless child is to be pitied. The disastrous effects of the prolonged absence of the father on the child are being seen now in Canada, in Great Britian and in France during this war. We are going to see something of it here in the United States if several hundred thousand fathers remain away for a long time. The effects upon the unhusbanded mother are bad enough; the effects upon the temporarily unfathered child are perhaps worse. We must prepare, too, to meet the problem of the permanently fatherless child in the reconstruction period.

The peculiar situation of an only child is worthy of special consideration. We know now that it is a very dangerous thing to be an only child. There are very real advantages when there are several children in a family, and the advantages are greatest when these several include both boys and girls, for boys and girls as playmates in the same family exert upon one another a beneficial, educative influence that can be obtained in no other circumstances. The only child, moreover, is likely to be too much with grown-ups and to be overindulged by them and by the parents. Contact with playmates outside, though very important for the only child, can never fully and satisfactorily replace contact with brothers and sisters in the same family.

The dangers of contact of young children with ignorant and unscrupulous servants cannot, in my opinion, be overestimated. In this country too many of the servants now accessible as children's nurses come from very low sources. Their ideals of family culture and of education are often wholly different from those of the families they enter. The children, if left much with such servants, get too much of their education on a low social level, instead of on the social level of their parents. More and more people seem to be willing to leave the education of their little children almost wholly to certain girls of the type mentioned. This can be only a mistake. The matter should be taken much more seriously than it is at present. Fortunately, many servants and children's nurses are excellent companions for little children. Among them are many sweet-natured, conscientious and high-minded persons who exert only a good influence upon the children. Indeed, among our newly rich I have more than once met with instances in which the influence of servants and nurses was more wholesome than that emanating from the parents!

Every parent should know what children his own child plays with, who they are, from what sources they come, how long the children are together and where and how they are supervised when they are at play. The reasons are obvious.

The timely sex instruction of the child should of course come from the parents or from the school. Most of it, I think, should come from the parents. It is exceedingly desirable that one of the parents at least, preferably both of them, should retain the full confidence of the child, keeping in sympathetic communication with it as it develops, so that when curiosity regarding childbirth, parenthood or the sex relationship arises in the child's mind the child will go to one or the other parent and have its curiosity satisfied by an explanation that is a true one, but suited to the age of the child at the time. Good judgment is necessary in deciding how far to go in explaining such things to children, but if the child's curiosity, when it has been aroused, be sufficiently satisfied with simple, suitable, honest statements by some one in whom it has confidence, all sorts of grave difficulties may be avoided. I would re-emphasize the fact that a sympathetic relationship between the children and the parents is essential. Many children who become erratic and delinquent do so because they did not have any one in whom they could at certain important times properly confide. Fathers and mothers too often fail to realize the importance of this. They should try to recall their own perplexities of childhood, when they wanted to know things about which they dared not ask their fathers or their mothers. The relationship between the child and its parents should, if possible, be so maintained that the child will ask spontaneously for information on the subjects under discussion, without any conscious effort on the part of the mother and father to influence it to do so. Confidential inquiries of that sort, if sympathetically and wisely responded to by parents, would save the children in many instances from injurious misinformation and sometimes from serious trouble. Children thus parented would not need surreptitiously to seek sex instruction from boys and girls in the neighborhood with whom they happen to be thrown in contact, or from servants. Moreover, if such children, as is often unavoidable, imbibe untimely or erroneous sex information from the extra-familial environment, they would take this at once to their parents, by whom any false ideas could be quickly corrected and through whom avoidance of undesirable contact would be arranged.

Another difficulty in the rearing of children that ought to be emphasized, I believe, is the overattachment that sometimes is permitted to develop between fathers and their daughters, and between mothers and their sons. The child's need of affection can, and should be, reasonably gratified by parents without exposing it to the dangers of overtenderness and without, as it grows older, protecting it so completely from the rough places of the world that it shrinks from facing the realities of life and tends to nestle snugly in an infantile paradise. Abnormal attachments between children and their parents are by no means uncommon. The psychoanalysts have laid a great deal of emphasis on these pathological relationships, and I think the subject should be ventilated. Whereas, normally, there should be deep and genuine affection mutually felt and exhibited, great care should be taken that it does not exceed normal limits and interfere with the later life of the child. There should be no cultivation of, or indulgence in, overfondness and overaffection, especially between mothers and sons, and fathers and daughters, for very often a fixation of the affections on the parent occurs that prevents the normal emancipation of adulthood. One of the things that parents must willingly learn to do is to consent to the setting of their children gradually free from themselves. The time comes for every developing personality when it should be released by its parents from all legal, social, intellectual and moral restraints, when, in homely words, the tub is not only permitted, but is required, to stand on its own bottom.

It is highly desirable that the affection of children for their parents should be strong and close in early childhood, at the time when the authority of the parents over the children is supreme, but the child should be gladly and relatively quickly taught by the parents to spread its affections over others in and outside the family, and should be shown how gradually to gain its independence from both the father and mother. A boy should never be tied too long to his mother's apron strings, and a girl should never be so fond of her father that she cannot fall in love with the proper man and go with him to live when the proper time for this comes. Many lives are being ruined, in my opinion, every day by this overfixation of affection—this overattachment of older children and adults to their parents. Surely none will misunderstand me here. I am not praising Goneril and Regan, and I admire Cordelia, whose love for her father was richer than her tongue, but even she left her father to marry a worthy husband.

A father should be careful not to carry his authority over a boy too long or make his rule of his boy too rigid, or the boy may develop a hatred for his father that may lead to all sorts of difficulties with father-substitutes later on. Thus, the boy may later transfer the hatred of his father to his teacher, or to any other father-substitute with whom he comes in contact, either in boyhood or in society in later life. It is believed by psychoanalysts that the world's quota of anarchists and fiercer revolutionists is largely contributed to by father-haters, that, indeed, their manifestations are in reality merely disguises of father-enmity. However this may be it would seem certain that much harm can come from overrigid treatment of a boy by his father. The father's full authority should be exerted only in very early childhood, when it is necessary to teach the boy to control the primitive impulses as the sentiments are being gradually developed by example, by precept and by contact with the social environment. The father and mother should not try to keep such full control of their children long, and they should face the prospect of giving up all control after a certain time. And at no time should more compulsion of children be resorted to than is absolutely necessary for the formation of normal, healthy habits.

A child should never be made to feel inferior, for a feeling of inferiority may do a vast deal of harm. Even if a child be subnormal, it is important to try to protect it from feelings of inferiority. Thus, if possible, a subnormal child should be kept from coming into conscious competition with normal children. When a physical defect of any kind is present, for example, a residual shortening of a leg from poliomyelitis, a facial paralysis or a spinal curvature, an effort to convince the child of the possibility of counterbalancing advantages should be made.

I have heard of a mother who always spoke of her little girl as an "ugly duckling." The child was not particularly handsome, but she was a good and attractive child. The mother, for some reason, was ashamed of that child, and gave expression to her shame always in front of other people. She would say, "There is my ugly duckling; what shall we ever do with her?" Sometimes she would remark, "She will never marry—that ugly duckling." Think of the discouraging influence of such comments upon the child!

During adolescence the child should be encouraged to face the real situations of life when confronted with them, and should be kept from turning away from them, or denying their existence, or finding sufficient satisfaction in the wish-fulfillments of daydreaming and phantasms. The so-called "autistic-thinking," which avoids reality and which indulges in pleasurable emotional states at the expense of wholesome objective activity is to be recognized when it exists, and any excess of it is to be combated, not directly by the prohibition of the pleasure-seeking automatism, but rather indirectly by sympathetic guidance in the processes of "reality-thinking" and by the encouragement of objective activities that compel plungings in the cold waters of actuality, that force swimming to avoid sinking, thus educating to self-reliance.

The problem of avoiding the spoiling of the child is, then, a large one. It involves biological, medical, psychological and social considerations. Heredity and environment are equally important. In the latter, along with strength of body, the chief stress is to be laid upon adequate provision for the organization of the mental life. Instinctive tendencies must have proper opportunity for expression; there must be education to sufficient self-control; attention must be given to the growth of the sentiments; the child must have opportunities to live out its fundamental traits, while at the same time it is subjected to the influences of the social surroundings and the ideals that will lead to the higher planes of conduct; and, finally, it must secure full emancipation from family, teachers and even friends, gnawing with its teeth, if necessary, its bonds asunder to gain its freedom. When we can see our way clear to such provisions we shall learn how to avoid "spoiling the child."

MENTAL DISEASES IN NEW YORK STATE DURING THE WAR PERIOD

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THE influence of the war in causing mental disease among our civilian population can never be definitely known. Our hospital records give a complete account of the disorders of the first admissions during the four years of the war, and we may compare the results during these years with those of preceding years; but when this is done we cannot be certain that changes in results are due to the war. It is but reasonable to suppose, however, that the war by increasing excitement, anxiety and grief has been a precipitating factor of no small importance in the causation of mental disease.

The available facts that have a bearing on the question may be set forth under the following heads:

I. Increase of insane patients in institutions.
II. Increase in first admissions.
III. Changes in the principal clinical groups.

I. INCREASE OF INSANE IN INSTITUTIONS

The statistics of the institutions for the insane in New York State are compiled by fiscal years. Prior to 1916 the fiscal year ended on September 30; since that time it has ended on June 30.

The yearly net increase in patients in all the institutions for the insane in the state since 1911 has been as follows:

Fiscal year	*Net increase*
1911	653
1912	662
1913	1,060
1914	691
1915	939
1916 (9 mos.)	918
1917	1,183
1918	937

The net increase in patients during the four years preceding the war was 3,066, or a yearly average of 767; the net increase during the 3¾ years following the outbreak of the war was 3,977, or a yearly average of 1,061. The difference between the increases in the two periods is quite remarkable, but it is accounted for in part at least by the accumulation in the hospitals of deportable aliens who could not be taken to their homes in Europe while the war was in progress.

Additional light is thrown on the subject by the following tabulation showing the ratio of patients under treatment to the general population of the state from 1908 to 1918.

Insane Patients in All Institutions at End of Fiscal Year

Year	*Number*	*Per 100,000 of general population of the state*
1908	30,457	349.6
1909	31,540	352.9
1910	32,658	358.3
1911	33,311	361.0
1912	33,973	363.6
1913	35,033	370.4
1914	35,724	373.2
1915	36,663	378.4
1916	37,581	383.4
1917	38,764	391.9
1918	39,701	395.7

It is seen that the rate per 100,000 increased 11.4 points from 1908 to 1911; 12.2 points from 1911 to 1914; and 22.5 from 1914 to 1918. The rates are based on the federal census of 1910 and the state census of 1915 and estimates made therefrom for the other years. As immigration has been greatly reduced by the war and as many men have been removed from the state for military purposes, it is probable that the estimates of population for 1917 and 1918 computed according to standard methods are too high. If this be true, the ratios of the insane to the general population for these years as given above are correspondingly low.

II. INCREASE OF FIRST ADMISSIONS

As the hospital population comprises many cases of long standing as well as recent admissions, it is believed that the first admissions form a better index of the rate of insanity during any given period.

In New York State first admissions have been carefully distinguished from readmissions since the beginning of the fiscal year of 1909. We are therefore able to compare the rate of first admissions during the war period with that of the years immediately preceding the war.

First Admissions to All Institutions for the Insane in New York State, 1909–1918

Year	*Number*	*Rate per 100,000 of general population of the state*
1909	5,784	66.4
1910	5,944	65.2
1911	6,228	67.5
1912	6,300	67.4
1913	6,650	70.3
1914	6,789	70.9
1915	6,690	69.1
1916 (9 mos.)	5,269	53.8
1917	7,340	74.0
1918	7,244	72.2

The average annual rate for the 4 years 1911 to 1914 was 69.0 and for the 3¾ years from 1915 to 1918, 71.7. For the reasons stated above, it is probable that the rates given for 1917 and 1918 are too low, but we shall have no basis for their correction until the data of the 1920 census are available.

III. CHANGES IN THE PRINCIPAL CLINICAL GROUPS

A closer view of mental disease in the state during the war period may be obtained by examination of the changes that have occurred during the past 10 years in first admissions with principal psychoses. For this purpose we take only the first admissions to the civil state hospitals and select the senile, paretic, alcoholic, manic-depressive, involution melancholia, dementia praecox and psychoneurotic groups. Together these constitute about 70 per cent of all first admissions.

First Admissions with Certain Psychoses, Civil State Hospitals, 1909 to 1918

Year	Senile	General paralysis	Alcoholic	Manic-depressive and allied forms	Involution melancholia	Dementia praecox and allied forms	Psychoneuroses
1909	606	658	561	574	207	1181	44
1910	615	815	581	769	143	1015	61
1911	583	758	580	826	143	1031	66
1912	596	719	567	854	119	1129	74
1913	594	768	572	924	133	1250	105
1914	542	774	464	880	188	1445	106
1915	570	814	345	879	165	1663	73
1916*	486	640	297	846	164	1173	57
1917	585	866	594	1136	201	1786	77
1918	652	913	354	976	219	1883	83

* 9 months.

Computing the average annual admissions for the 4 years 1911 to 1914 and for the 3¾ years 1915 to 1918, we have the following results:

	Average annual admissions 1911–1914	*Average annual admissions 1915–1918*	*Per cent of increase or decrease*
Senile	579	611	5.5
General paralysis	755	862	14.2
Alcoholic	546	424	22.3*
Manic-depressive and allied forms	871	1023	17.5
Involution melancholia	145	200	37.9
Dementia praecox and allied forms	1214	1735	42.9
Psychoneuroses	88	77	12.5*

Referring to the foregoing figures we note a slight increase in senile cases and a more marked increase in cases with general paralysis. The etiology in these groups is well known and it is probable that the war is not responsible for the increase to any great extent.

In the alcoholic psychoses the decrease in cases may have been influenced by the restrictions placed on the liquor traffic during the war, but a marked decline in the influence of alcohol in causing insanity was noted the year before the outbreak of the war. The reasons for the rise in the number of cases in this group in 1917 and for the sudden drop again in 1918 are not known.

In the manic-depressive, involution melancholia and dementia praecox groups the increase in the annual number of admissions during the war period is quite striking. In dementia praecox especially the change has been remarkable. Part of this increase may be due to modifications in diagnostic principles, but in the main the figures may be taken at their face value.

The influence of the war in bringing the constitutional cases of mental disorder into the hospitals is a matter of conjecture. It seems but reasonable to ascribe a part of the increase in the annual admissions in these groups to the mental conflicts arising from circumstances connected with the great war. Social and economic changes produced by the war may also have a bearing on the matter.

The annual rate of first admissions of the psychoneurotic group decreased during the war period. However, as this group is so small and is subject to such marked variations no significance can be attached to the change during the war period.

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* Decrease.

The full effects of the war have not yet reached the state hospitals. The influences thus far felt are not those of actual army service, but rather the secondary currents that have reached the civilian population. Most of the soldiers who became insane in active service are being cared for in army hospitals. Many of those who recover from the first attack and are discharged are likely to appear later in our hospitals as readmissions. It is also probable that there are a large number of soldiers, who have suffered severe mental strain during the war, that will be unable to make the adaptations necessary to success in civil life. Some of these will ultimately need treatment in the state hospitals.

CONCLUSIONS

1. It can be reasonably inferred that the war has been a precipitating factor in the causation of some forms of mental disease among the civilian population.
2. The number of patients under treatment in institutions in the state increased more rapidly during the war period than during the four years preceding the war. The increase was due in part to the accumulation in the hospitals of deportable aliens.
3. The ratio of first admissions to the general population of the state increased during the war period.
4. The rate of alcoholic insanity decreased during the war, especially in the years 1915 and 1918.
5. Marked increases occurred during the war period in first admissions in the manic-depressive, involution melancholia and dementia praecox groups.
6. It is probable that further increases in the rate of mental disease will occur following the return and demobilization of the army.

MENTAL TESTS*

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AS long as there has been even the slightest amount of organized social life, so long have men sized up their fellow men. In meeting another in business, in professional, or in sociable intercourse, a man makes a judgment as to what characteristics that other individual has, and what sorts of things he is capable of doing. This judgment is based on the reports of others, on the other's method of conducting business, or on his manner of meeting people. A special tone of voice, the manner of address, interruptions in conversation, and comments on friends and acquaintances, are often the basis of a marked prejudice for or against an individual, in other words of a judgment regarding the capabilities and the characteristics of the person. It is at best but inspection with a certain modicum of logical considerations that make up this casual judgment. But in this casual judgment we find the nucleus of the more systematic and scientific method of grading intelligence which has become prominent in the past few years.

Besides the simple method of inspection, resulting in the casual judgment, other methods came into vogue. It was appreciated that a man might look like a fool, but be capable and even brilliant in a certain line of endeavor, and that a man might look perfectly normal and very capable, but actually be a fool. Heredity was used as a basis of judgment. "Like father, like son," was the saying. Certain families were supposedly distinguished from others by the possession or lack of certain characteristics. The son of a good boot-maker was thought to be capable of becoming a good boot-maker, the son of a capable farmer was thought to be capable of becoming a farmer, and so on throughout the various trades and professions. This simple method of making judgments had a firmer basis of extended observation, as we now look at the matter in accordance with our present scientific knowledge. Nowadays we put the matter in slightly different terms. We say the boy living in a certain environment has acquired certain habits (or conditioned reflexes) which enable him to react appropriately under certain conditions of stimulation. Thus, the child of a boot-maker has the opportunity to form certain habits in relation to leather and its workings, to the grades of material, to the use of different implements, to complaints about boots, etc. These habits are, it is understood, important in the manufacture of boots. In so far, therefore, as habits are indications of intelligence this method is important, but it is also too unsystematic. It takes into account only the special environment; it but takes the obvious and fixes this with too much meaning and significance.

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This method of judgment from heredity and partial environment does not coincide any too accurately with the individual's capabilities and his characteristics. Not infrequently it happened that the warrior's son was too peace-loving, and the shoemaker's boy sometimes became a poet. How, then, can one determine the child's or the man's capabilities better than by the method of casual inspection and better than by the method of heredity? Can this be done for a special occupation, such as that of a priest, or can this be done only for general intelligence? The need for a better method was appreciated, and different suggestions have been made. Only one of these historical methods need detain us here. The most noteworthy of the attempts was that of Gall and his partner, Spurzheim. Starting with the assumption that the brain is the all important determiner of action, but with a grossly inadequate knowledge of this organ, the proposition was set forth that bumps on the outside of the head show the conditions within, and that these bumps can be "read" in terms of talents or aptitudes, of inclinations and of other special characteristics. The vogue that phrenology had with those who had any pretense to psychological or other scientific training and knowledge has passed, because it also was a very indirect method of determination. Unfortunately, however, there are still those who "read bumps," just as there are those who depend upon the lines of the hand to determine future successes as well as past performances, and those who think they are able by examining a specimen of handwriting to detect characters of persons unknown in other ways. One might equally well judge another's wealth by the kind of clothes he wears, his knowledge by the number of books in his library, and his habits of thought by noting how he has his hair brushed. It is more to the point to know whether or not the person pays his tailor, whether or not his library is a legacy, and whether or not his wife insists on having his hair brushed in a certain fashion.

All of the methods of estimating intelligence which have been mentioned considered parts of the personality which have relation to intelligence, but which do not measure intelligence. Since the object of tests or the selection of criteria was for the purpose of determining mental things, it should have been obvious that the tests should involve not the clothes one wears nor the way one brushes his hair, but what one knows and how readily one can acquire new mental things, make new adjustments, and use what one knows. These matters are given weight in the more recent scientific testing of intelligence. It is clear, however, that to determine the relative intelligence of an individual, we should find out how many things he knows, how readily he learns new things. These facts must be correlated with the environment—*i. e.*, the opportunities the person has for learning—and with his age. In addition, it is essential that the person be judged in relation to others of the same environment. But even though this process of examination or testing were possible, it would be impracticable. It would be necessary to examine a person in every possible way. This would take days, or even months and years. How to make tests that fairly accurate estimates can be made, and at the same time not take too long and thus involve too great labor and expense, is much the same as in every science. From a large bar of steel the chemist takes a few small samples, determines the composition of these and bases his judgment of the whole bar by making comparisons of the samples with each other and by averaging the determinations as indications of the "general" composition of the whole bar. So also, the metallurgist takes samples from different parts of a mine, and reports on the average of gold per ton of ore, and also may report the occurrence of more per ton in one place than in another. It remained for Binet, a psychologist, and Simon, a physician, to make these matters plain for mental testing. The investigations conducted by Binet and Simon enabled them to say that normal children of a certain age and a certain environment normally knew certain things. In other words, if a child could be "sampled," it would be possible to make a few simple tests like those of the chemist and thus determine the "mental age" or the intelligence of that child.

Thus it became apparent that a mental test having for its object the determination of general intelligence or mental capacity, should determine the character and the amount of an individual's knowledge. This is to be done in much the same way as in other testing, by taking samples or by making a cross section and using it as a basis of judgment. The ideal method of making a test for intelligence rating would be to have one test, or question, which could be put and receive one answer, and by the character and the completeness of that answer to make a suitable judgment. But because persons differ widely in many ways, many questions (tests) dealing with these matters of difference must be used, and the responses to all tests form the basis of judgment.

The original Binet-Simon group of tests has since been largely modified, some tests have been discarded, other tests have been introduced. The method of scoring (*i. e.*, in comparison with the task of the chemist, the method of analysis, upon which a final judgment is made) has also been altered. Lately other groups of tests have been devised and applied. All of these determine knowledge or lack of knowledge. In many groups of tests, and this applies also to individual tests, there is a limitation in that largely on the ability of the subject to use language hinges the grade to be given. This is a potent adverse criticism of the whole procedure of tests which are based upon or which resemble the original Binet-Simon group. If an individual uses language well, his mark, or grade, is correspondingly high, and vice versa. In short, mere verbosity may sometimes pass, in testing as in ordinary life, for native intelligence. Then there is the condition of nervousness, whether shyness or embarrassment, which prevents many a person showing at his best. Because of this there has been introduced a newer method of testing which involves language to only a slight extent.

The tests of Binet and Simon determined as far as they could the mental level of normal children of a certain environment, and were then applied to children of all sorts and conditions—feebleminded children, inmates of corrective institutions, children of the slums, and children of wealthy parents—and it was found that the tests do in general determine a kind of mental level. Recently testing has been extended in different directions to determine the mental level of adults, and these extensions of the original Binet-Simon tests are of special interest to the psychiatrist. The widest application of tests to adults has been in connection with the mental examination and classification of recruits for the army. More than a million men were tested and the results of these tests, when they are published, should furnish valuable comparative data for the determination of normality and abnormality which is one of the chief functions of the psychiatrist. The army tests rely less on the language ability of the subject, but many of them do require that the subject shall be able to read, be able to understand what is said, and carry out the orders which are given.

Another kind of test appears to have wide application, the outcome of practical tests which have been used for years. A manufacturer hiring a machinist may determine his competency by finding out, if the applicant tells the truth, what kinds of positions he has previously held, or he may determine it in a very practical way by getting the applicant for a job to show his ability at a lathe or other machine to which he may be assigned. Or the builder hires a bricklayer, and pays him while his competency is being determined. Such practical tests are, however, expensive. They risk costly machinery and materials, and if an unskilled man be permitted to try to do work for which he has no competency he may endanger the lives of others as well as his own. Tests have been devised so that the ability of a machinist, for example, may be determined without the danger of loss of material, destruction of tools, and the payment of wages. Other occupational tests have also been devised to test the fitness of applicants for other kinds of work, and in some cases it is possible by means of tests to determine the relative skill of an applicant, whether he be novice, apprentice, journeyman, or expert. Many of these tests are of the character known as "performance" tests, and are relatively independent of language ability. Some are entirely independent of language ability, either of expression or of understanding, except in so far as gesture is a part or a kind of language.

In making tests of mental intelligence it is necessary (1) that questions or problems be presented which are known to be answerable or soluble, and (2) that data be available on many individuals of known intelligence or skill to determine at what level of intelligence or skill each question is likely to be answered, or each problem solved, in whole or in part or rightly or wrongly. The lack of appreciation of the latter point is apparent in some of the work that followed the publication of the Binet-Simon series of tests. For example, these tests which were devised for children have been applied to senile dements, to general paralytics, and to other abnormal cases to determine their "mental ages" in comparison with children. With equal right, because of the occurrence of the Babinski phenomenon in the infant and in the adult hemiplegic, one might infer that the hemiplegic's nervous system is like that of the infant. If, therefore, tests are to be used for diagnosis, whether of mental age or any other condition, it is necessary to have data on normal people of the same age and of the same social status. It is not sufficient to say: "I know this, and any one who does not know it is abnormal." Norms must be established.

In the case of children this problem is simple enough, for the different grades of school furnish such a standard of intelligence, and thus it is possible to determine the reactions of children at different levels of school life. But it is not so with adults. Here the examiner must often rely on the known or the reported success or failure of the individual under examination, or on his capacity or inability to learn as shown in his relations to others, and the test must, therefore, be standardized with these extraneous facts. The examiner must get data on the characteristics of the individuals to be tested by the tests he selects. Are the people successful in business? Could a laborer, or an artisan, or a professor answer these questions or solve the problems which are presented? By testing the tests one can eliminate those tests which apply to only one or two groups of individuals. Or one may, if it is desirable as in the case of trade or occupation testing, devise special tests to fit special conditions. At the same time one may also devise and standardize tests which will quickly divide large groups into smaller groups, such as the poorly educated who are not able to solve a certain set of problems, but who can solve another set that cannot be solved by those with no education.

There is yet another element to be considered in making tests or determinations of mental level—the speed of performance. It is important to know not only "Can he do this?" but also "Can he do twice as much as another?" One who knows twice as much as another, who can adapt himself in one half of the time, or who can perform twice as much intellectual labor in a given time, is more intelligent than the other individual. In the army testing scheme this consideration was taken into account and it enabled the examiners to determine different degrees of knowledge or intelligence. For example, it was not only a matter of whether or not a man knew that 12×16=192, but it was also a matter of how rapidly he could demonstrate his knowledge. In other words, accuracy of thinking is combined with quickness of thinking in the most intelligent, and the two factors—accuracy and speed—must be duly considered in making any proper estimate of mental ability.

In the early days of the utilitarian tests it was believed, and unfortunately is still believed in some quarters, to be too great a refinement to carry out the tests with complete accuracy. Such a test is, though, only a kind of sampling. It is rather like a chemical test, in which it is well recognized that comparable results are not secured if one tester uses diluted sulphuric acid, and another uses concentrated acid, or if one uses water as a solvent and another uses alcohol for this purpose. It should be unnecessary to say that it is essential that the same processes be established in the application of mental tests of a certain character. Only in this way can we expect to have results that are comparable. Let us consider a concrete instance. A child is asked, "What color is a two-cent stamp?" A direct answer to this question permits the child to report any color name. But ask the child, "Is a two-cent stamp red?" and he has but two possibilities—"Yes" and "No." Or ask, "Is a two-cent stamp red or green?" and there are only two possibilities directly given, with the third possibility that a negative answer will be given. So it is with other tests. Varying methods may be expected to give varying results.

It is in the interpretation of the tests that one of the main difficulties lies. As tests are mental samplings, so the investigator must consider the results of his samplings as the prospector and the metallurgist consider their ore. One point that must be noted is that a child or adult be not judged too harshly on the result of one test. It may be that the mental mine has been sampled at a point where relatively poor ore is to be found. If the whole is to be judged, more than one sample should be taken for test. Thus the rural child is of far different environment from the city child, and should not be expected to test in the same manner. When we deal with adults we must bear in mind that their environments—business, professional, educational, social, and what not—have been much more varied than those of children who have been compelled to go to school. Children because they have had the school environment are to be expected to test more nearly alike than adults who in many ways have been changed by their environments—by the daily press and magazines, by mail order catalogues, and the like.

DRUNKENNESS AS SEEN AMONG WOMEN IN COURT

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ONE of the commonest charges against women offenders in court is drunkenness. How widespread is its prevalence; how serious are its many ramifications into the social life of the community, it is not the purpose of this article to discuss. But this group of individuals presents, in common with other types of delinquents, certain medical features that may be very well worth considering. We hope that such a study may throw some light on this particular aspect of the problem. The data presented for discussion were obtained from the records of the last 100 cases of drunkenness among women referred to the medical service of the Municipal Court of Boston.

In four fifths of the cases there was a special query concerning the individual's "physical fitness for employment." In other words, in the majority of all cases referred, this was the idea that was uppermost in the mind of the probation officer. It is evident that in questioning their "physical fitness" the probation officer did not mean to imply that she had selected these eighty persons because they were suffering from some well-marked physical disease, for careful examination showed that 71 of them were in good or fair physical condition. But the intelligent probation officer, having continually in mind the serious handicap that physical disease may prove to industrial efficiency and the danger of venereal disease to the general public as well as to the individual, as a matter of course seeks information on these points wherever possible prior to securing employment for the individual.

Evidently the great majority of these 100 cases were considered fit by the court for supervision on probation, for 64 had had their cases already disposed of, and had been placed on probation prior to being referred for examination.

It is the purpose of this paper to present certain medical facts that would appear to be intimately related to the data the court had in its possession at the time of the disposition of the several cases. It is hoped that these facts will throw some light on the cases under consideration. Before doing this we should like to present a few tables, showing the ages, living conditions, marital status, employment history, alcoholic habits, frequency of offense, disposition, etc., of the 100 cases of drunken women whom we are considering.

Table 1.—Ages

Under 20 years	1
21–30 "	31
31–40 "	43
41–50 "	16
51–60 "	6
61 years or over	3
	100

A great majority of these persons—74 per cent—were young adults, ranging from 21 to 40 years.

Table 2.—Living Conditions

At home	46
Rented room	42
No address	12
	100

Forty-six per cent of these 100 women lived at home; 42 per cent in rented rooms; while 12 per cent were "floaters," having no address.

Table 3.—Marital Status

Single	26
Married	32
Widowed	14
Divorced	2
Separated	25
Married (husband in service)	1
	100

Of these 100 cases 26 had never married; 74 had been married, but only 32 were living at home with husbands.

Table 4.—Employment History

Regularly employed	11
Irregularly employed (frequent changes)	30
Odd jobs	14
No work	16
Housework at home	29
	100

Only 11 out of the 100 cases had been steadily employed; 30 worked irregularly, changing positions frequently; 30 either never worked at all or simply did odd jobs; while 29 did their own housework at home.

Table 5.—Alcoholic Habits

Occasional	26
Periodic	48
Steady	26
	100

In only 26 of the cases were we dealing with persons who had not formed well-marked alcoholic habits, 74 of these individuals having become habitually accustomed to its use. Two were also drug users.

Table 6.—Frequency of Offense

1st Arrest	31
2nd Arrest	12
3rd Arrest	12
Recidivist	45
	100

While 69 had been in court before, the majority of these cases would, from the point of view of their court records, still be considered mild offenders. It might be mentioned that in addition to arrests for drunkenness, these 100 offenders were arrested 29 times for offenses against chastity; 6 times for larceny; once for violating the drug law; 3 times as "stubborn child"; and once for assault and battery.

The treatment meted out by the court to these individuals is shown in the following table:

Table 7.—Court Treatment

	1st Arrest	*2nd Arrest*	*3rd Arrest*	*Recidivist*
Cases under consideration	31	12	12	45
Released by probation officer	..	8	13	127
On file	..	..	4	124
Probation number of times given	31	15	17	145
Broken	..	1	5	87
Inside probation	..	2	1	23
Now on probation	31	10	9	21
Dismissed	..	2	2	14
Penal treatment:				
Fixed time	..	..	3 mos.	142 mos.
Indeterminate sentences	..	1	..	54
Dismissed by court	..	..	..	1

There were 31 first offenders, each one was given probation, and at the time of examination was on probation. There were twelve second offenders; these individuals had been released eight times by the probation officer without bringing them to court. In 16 instances they were brought to court, placed on probation in 15 cases, and once given an indeterminate sentence. While on probation one had to be surrendered to the court; two were placed on inside probation, that is, confined to the House of the Good Shepherd or the Welcome House. Two were dismissed.

There were 12 third offenders, totaling 36 arrests. In 13 instances they were released by the probation officer without bringing them to court. In 23 instances they were brought to court; their cases were put on file 4 times; they were placed on probation 17 times, and sentenced twice. While on probation, five had to be surrendered to the court, and one placed on inside probation; two probationers were dismissed as successful, and nine were on probation at the time of examination.

The 45 recidivists were released 127 times by the probation officer without bringing them to court, they were rearrested, brought to court and their cases put on file 124 times; they were again rearrested, brought to court and placed on probation 145 times; 87 times they broke their probation and had to be surrendered to the court; they were placed on inside probation 23 times; their probation was dismissed as successful 14 times; while 21 are at the time of this writing on probation. The court in addition had tried out penal treatment with these individuals, and had sentenced them in fixed time to 142 months of imprisonment; and in addition had given them 54 indeterminate sentences either at the State Farm or the Reformatory for Women. One was dismissed by the court.

If the purpose in view has been a therapeutic one, if the aim has been by the application of such treatment to prevent further recurrences of alcoholism, we are compelled to admit that some of these cases have not responded properly to treatment. But a careful study of these individuals themselves will show in the first place, that we are dealing with abnormal material; and secondly, that our recidivist group is composed for the most part of individuals suffering from pathological conditions, who because of such handicaps cannot be expected to adapt themselves as satisfactorily as normal persons to the usual methods of treatment employed by the court.

Seen from the viewpoint of personality, we are dealing in the majority of cases with persons who possess abnormal mental traits and characteristics sufficiently well marked to influence their behavior strongly.

Table 8.—Relationship of Personality to Frequency of Offense

	1st Offender	*2nd Offender*	*3rd Offender*	*Recidivist*	*Total*
Egocentric	10	2	4	16	32
Emotional	12	7	5	27	51
No difficulties	9	3	3	2	17
Total	31	12	12	45	100

Eighty-three were more or less abnormal personalities, in some cases certain dominant characteristics being present which tended to be very harmful to the personality itself, while in other instances there were traits indicating disregard for the rights of others which made future conflicts seem probable. Thirty-two persons were placed in the egocentric group. They were selfish, egoistic, unappreciative and inconsiderate of the rights of others, unwilling to accept authority or to be guided by advice; they were suspicious, stubborn, superficial and often very indolent. Fifty-one were placed in the emotional group. They were unstable, impulsive and easily discouraged, very sensitive, excitable and quick tempered. This type of individual goes to pieces in emergencies; as long as things go well in their environment the adjustment may be adequate, but upon the occurrence of difficulties they seek to avoid facing reality, either through forgetfulness in alcohol or through some other equally unfortunate method of avoiding the situation. The periodic drinker was found common in this group. Seventeen women showed no serious personality difficulties. There were 55 persons in the group who had been arrested once, twice or three times; 15 of these or 27.3 per cent showed no evidence of personality difficulties. There were 45 who had been arrested over and over again, and were placed in the recidivist group; of these cases, only two or 4.4 per cent showed no well-marked personality difficulties.

Table 9.—Relationship of Mental Defect and Disorder to Frequency of Offense

	1st Offender	*2nd Offender*	*3rd Offender*	*Recidivist*	*Total*
Normal..........	7	1	1	2	11
Dull Normal.....	13	1	1	6	21
Epilepsy.........	2	1	3	2	8
Psychopathic personality.....	..	2	1	7	10
Feeblemindedness	4	4	4	20	32
Psychosis........	4	3	..	4	11
Alcoholic deterioration...........	1	..	2	4	7
Total........	31	12	12	45	100

Sixty-eight of these individuals were clearly distinguishable as abnormal mental types, of whom 32 were feebleminded. One out of every nine persons was psychotic and was suffering from an active mental disturbance, usually alcoholic in origin. Of the first, second, and third offenders, 56.4 per cent showed some form of mental defect or disorder; 82.2 per cent of the recidivists showed such mental handicap.

We must remember in this connection that drunkenness in women does not present the same features as in men. Not only is it less common, but addiction to alcohol with them means a further step downward than it does with men. As a consequence we should expect to find among women taken up from the streets and from cafés because of drunkenness, a larger percentage of mental defect and disorder. This expectation has been fully met in all our work, for mental inferiority is more common among women arrested for drunkenness than among men. The definite relationship between mental defect and disorder and the frequency of offense is well borne out in the study of this group, as it has been in all other types of offenders that we have investigated.

It is not enough, however, merely to call attention to this relationship. We may well emphasize the fact that reconstructive measures designed to prevent further delinquency and to rehabilitate the delinquent, if not based upon a thoroughgoing knowledge of the delinquent himself, his abilities and disabilities, promise little in the way of real and lasting success.

Table 10.—Relationship of Physical Condition to Employment

	Regularly employed	Irregularly employed	Odd jobs	No work	Housework at home	Total
Good	7	5	..	1	1	14
Fair	4	22	7	6	18	57
Poor	..	3	7	8	8	26
Bad	..	..	..	1	2	3
Total	11	30	14	16	29	100

From the above table we see that 71 of these cases were in good or fair physical condition; while 29 were in poor or bad physical condition and in need of medical treatment. Eleven persons were regularly employed, all of whom were in good or fair physical condition. Forty-one were self-supporting, 38 or 92.6 per cent of whom were in good or fair physical condition. Of the seventy-one persons found to be in good or fair physical condition 38 or 53.3 per cent were self-supporting. Twenty-nine persons were in poor or bad physical condition, only 10.3 per cent of them being self-supporting. In this particular group the chances for being self-supporting were four times as good among those in good or fair physical condition, as it was among those in poor or bad physical condition.

The relationship that venereal disease bears to this problem of drunkenness, it seemed to us, was of sufficient importance to justify special study. The following table we feel is a conservative estimate, as only cases were included that had positive Wassermann reactions and in whom gonococci were found, although the well-known interference of alcohol with the Wassermann reaction must have caused us to exclude many cases of syphilis. The bacteriological and Wassermann work in these cases was done in the laboratory of the Boston City Health Department.

Table 11.—Relationship of Venereal Disease to Offense

	Drunkenness only	Drunkenness and other offenses than against chastity	Drunkenness and offense against chastity	Total
Syphilis	13	1	10	24
Gonorrhea	11	1	2	14
Combined syphilis and gonorrhea	3	..	1	4
Doubtful blood	2	..	..	2
Doubtful smear	2	..	..	2
Blood not taken	10	2	4	16
Smear not taken	10	2	4	16

Only 84 persons had blood and smears taken; 40.5 per cent of these were positive—34 persons out of the 84 examined for venereal disease were found to be suffering from syphilis or gonorrhea, or both. It will be seen from the above table that these diseases are not limited to those with a history and record for offending against chastity. Sixty-nine persons had been arrested for drunkenness only, and there was no evidence presented to the court that they had been immoral; and yet 36.6 per cent were found suffering from syphilis or gonorrhea or both.

Venereal disease has long been considered in the popular mind as purely a moral problem—a condition to be found only among prostitutes, and contracted through sexual relations alone. Such is undoubtedly the principal source of infection; but syphilis and gonorrhea are also contagious diseases and are subject to the same laws as govern such conditions in general. They may, and sometimes do, affect wholly innocent persons. We do not pretend to say how many of these cases in question were innocent infections, but we were impressed with the fact that even in those suffering from venereal disease, drunkenness, and not sexual irregularities, was the outstanding problem.

The following facts are interesting in the study of these 100 women:

Sixty-four persons—almost two thirds of these cases—had been placed on probation prior to examination; 69 as shown by a study of the record cards, had been in court before, and 45 had been arrested repeatedly, were old offenders, and had not profited well by the usual court treatment.

In 83 of the cases, we were dealing with abnormal personalities—individuals who possessed certain mental traits and characteristics sufficiently well marked to have strongly influenced their behavior along abnormal lines.

Sixty-eight of these persons were suffering from pathological mental conditions, feeblemindedness ranking highest—32 cases.

Of first, second and third offenders, 56.4 per cent showed some form of mental defect or disorder.

Of the recidivists 82.2 per cent showed mental handicaps of one form or another.

Twenty-nine persons were in poor or bad physical condition.

A definite relationship was noted between the physical condition of these persons and their ability to support themselves, in that the chances for being self-supporting were four times as good among those in good or fair physical condition as it was among those in poor or bad physical condition.

Of the 84 cases having blood and smear tests made, 40.5 per cent were found to be suffering from venereal disease.

The success or failure of whatever treatment the court may employ in such cases will in a great measure depend on the possibilities of each individual offender, and the adjustment of treatment to suit the particular needs of each case. Much can be done for an individual, even though he may suffer from physical and mental handicaps, providing an early diagnosis is followed by an understanding effort to treat his particular difficulties.

NOTES AND COMMENTS

California

A bill has recently been presented before the general assembly which would provide for the establishment of a psychopathic hospital to accommodate at least one hundred patients. The management of this hospital would be vested in a board of trustees, consisting of the medical superintendent of the state hospitals, the president of the California Medical Society, the deans of the medical departments of the University of California and Leland Stanford University, a neurologist, a psychologist and two other persons, the last four to be appointed by the governor. The bill states as the purposes of the hospital: "The study of abnormal mental states, their nature, causes, results, treatment and prevention; education regarding such abnormal mental states; the dissemination of knowledge in such matters; the care, observation and treatment within the wards of such hospital, out-patient department, or elsewhere in the state, of persons suffering from insanity and other abnormal mental states; the investigation in any part of the state into the primary or precipitating causes of insanity; to cooperate with local or state authorities and institutions in preventing abnormal mental states and aggravation thereof by unfavorable environment."

Another bill recently introduced would create a department of psychiatry and sociology at the state penitentiary at San Quentin. To quote from the bill: "Within ten days after this act goes into effect, the governor shall appoint a psychiatrist, a psychologist and a sociologist. The psychiatrist shall be the chief executive of the department of psychiatry and sociology, and shall have had training for at least one year in one of the state hospitals for the insane. Each member shall be appointed to hold office for a term of four years. The governor shall fill all vacancies created in said department by the appointment of the same kind of specialist as was his predecessor.

"It shall be the duty of the board of prison directors to make and adopt such rules as are necessary for the conduct of the business of the department of psychiatry and sociology; to provide equipment for said department with necessary furniture, fixtures, apparatus, appurtenances, appliances and materials for the proper conduct of said department.

"It shall be the duty of the members of said department to conduct an examination and investigation of the case of every person committed to the state penitentiary at San Quentin.

"It shall be their duty to define from a psychiatric, psychological and sociological standpoint, the type of problem presented in each case; to make a scientific analysis of the various causative factors operative in each case; to outline the most promising plan of treatment for meeting at the same time the needs of social security and the individual prisoner's reclamation; to bring to the attention of the prison directors and the warden of the state penitentiary at San Quentin the method of treatment proposed in each individual case.

"It shall be the duty of the members of said department to make an annual report to the governor and prison directors, such report to include the plan of treatment suggested, the treatment given, and the result accomplished."

An appropriation of $30,000 for equipment, maintenance and salaries, is included in this bill.

The following bill relative to the reception and temporary care of persons suffering from mental disorder has recently been presented before the legislature of California:

"The superintendent of any hospital for the insane, public or private, may, when requested by a physician, or by a member of the board of health of the state, county, city, or city and county, or a peace officer of a city, town, county, or state, or by the judge or district attorney of a county, receive and care for in such hospital as a patient, for a period not exceeding thirty days, any person who needs immediate care and treatment because of mental derangement. Such request for admission of a patient shall be put in writing and filed at the hospital at the time of his reception, or within twenty-four hours thereafter, together with a statement in a form prescribed or approved by the state board of insanity, giving such information as said board may deem appropriate."

Delaware

The institution for the feebleminded, authorized by legislative enactment in 1917, is to be located in Sussex County near Selbyville. The land which is valued at $39,000 was purchased through individual subscriptions, without cost to the state.

Georgia

The studies of the Georgia Commission on the Feebleminded have aroused a keen interest throughout the state. Public sentiment in favor of a state institution for the feebleminded has been created through the Commission's investigations of public schools, orphanages, jails, almshouses, reformatories, state prisons, and the special studies of juvenile court cases and of typical degenerate families. The work of the Commission has the sanction and hearty cooperation of medical associations, women's clubs, business men, teachers and parent associations. The State Federation of Labor at a recent meeting adopted resolutions strongly endorsing the work in behalf of the feebleminded and urging the local organizations in the state to ask the support of their legislators for state provision for the feebleminded. The Commission expects to complete its studies by the end of May. Its report with recommendations will be presented to the legislature, which convenes in June.

Illinois

To relieve the overcrowding at the Lincoln State School and Colony, for the feebleminded, and to accommodate the large number of feebleminded awaiting admission, it is proposed to enlarge the new epileptic colony at Dixon to a capacity of 1,000 patients, and to admit feebleminded persons to it. The law creating the Dixon State Colony, in 1918, made admission voluntary on the part of the patient and, as a consequence, not more than 100 persons have made application for admission. It is not intended to abandon the epileptic colony, but to erect cottages in unit groups that will be well suited to the care of this class of patients, and to use the existing buildings for the feebleminded.

Indiana

A number of laws of special interest were enacted by the 1919 legislature of Indiana. One makes provision for a new institution for the feebleminded, to be built in the southern part of the state on a tract of land containing not less than one thousand acres. Another law provides for the court commitment of feebleminded children between the ages of six and sixteen years to the School for Feebleminded Youth, at Fort Wayne, upon the application of a reputable citizen of the county and after an examination by two qualified physicians. By the terms of another law, voluntary admissions to the state hospitals are authorized, and also the establishment of free mental clinics by these hospitals. Social workers and visiting nurses are to be employed in the prevention of mental diseases and after-care of patients who have left the hospitals. An appropriation of $350,000 for a colony farm has been made to the Central Hospital for the Insane, located in Indianapolis, and a special fund of $400,000 will make possible a further extension of the colony system. The Village for Epileptics has received a substantial appropriation for cottages for women. Heretofore, this institution has not been able to admit women. Additional cottages for men will also be provided. The erection of industrial buildings at four of the state institutions is provided for by the appropriation act. A division of venereal diseases and one of child hygiene have been provided for in the State Board of Health.

Iowa

A law "to better provide for the care and detention of feebleminded persons" has been enacted by the 1919 legislature, to become effective in July of this year. This law makes provision for the commitment of a feebleminded person through the petition of a relative, guardian, or reputable citizen in the county of his residence, after he has had a court trial, a notice having been served upon him within ten days previous to the trial. The court may require the alleged feebleminded person to be examined by a qualified physician or a psychologist, and also may require the petitioner to answer under oath any questions propounded in a form prescribed by the Board of Control.

The hearing on the petition shall be by the court, and a commission to be appointed by the court, of two qualified physicians or one qualified physician and one qualified psychologist, selected by the judge.

If the alleged feebleminded person is found to be feebleminded, the court shall enter a decree, appointing a suitable person to be his guardian, or directing that he be sent to a public institution for the feebleminded or to a private one qualified and licensed under the laws of the state.

Another provision of the act states that when a child is brought before a juvenile court as a dependent or delinquent child, if it appears to the court that such child is feebleminded, the court may adjourn the proceedings and direct some suitable officer of the court or other suitable person to file a petition under this act; and the court may order that pending the preparation, filing and hearing of such petition the child be detained in a place of safety or be placed under guardianship of some suitable person.

This act also provides for the transfer of patients between the hospitals for the insane and the institution for the feebleminded.

Kansas

Senate Bill 553 provides for the voluntary admission to a state hospital for mental disease of any person making written application, provided he produces a statement from his attending physician, or from the county physician of his county, that he is in need of treatment, or the superintendent is satisfied that the applicant is in need of such treatment. Such patient shall not be detained longer than ten days after he has given notice in writing of his desire to leave the hospital.

A bill has been enacted by the 1919 legislature changing the name of the State Home for Feebleminded to the State Training School. Another law provides for a simplified form of commitment to this school. It permits the adjudgment of mental defect on the recommendation of two qualified physicians or of one physician and one psychologist, and allows commitment without the consent of parents or guardians.

Maine

Among appropriations made by the recent legislature are $125,000 for new construction at the two state hospitals, and $36,500 for the same purpose at the school for the feebleminded.

A progressive step in the legislation with reference to the commitment and care of persons with mental disease is Chapter 232, Laws of 1919, State of Maine. This act provides for (1) commitment for observation, by judges and other persons, upon the certificate of two physicians qualified as examiners in insanity; (2) voluntary admission to the state hospitals of persons desirous of submitting themselves to treatment; (3) temporary commitment of persons requiring care in a state hospital, for a period not exceeding fifteen days, upon the request of a physician, a member of the board of health, a health officer or a police officer; (4) community service. This last provision requires the state institutions for the insane, the feebleminded and the epileptic to organize community service, with the following purposes: (a) to supervise patients who have been discharged; (b) to inform and advise any indigent person, his relatives and friends or the representatives of any charitable agency, as to the mental condition of any indigent person, the needed treatment, and the institutions and the other means available; (c) to cooperate with other state departments; (d) to acquire and disseminate knowledge of mental disease, feeblemindedness, epilepsy and allied conditions.

Massachusetts

In the report of the special commission, created in 1918 by legislative enactment, to investigate and consider methods of treating inebriates, feebleminded persons, defective delinquents, criminals and misdemeanants, the following conclusions are found:

1. "The present disintegrated and unrelated system under which criminals and misdemeanants, both juveniles and adults, are confined and cared for in our 34 penal and correctional institutions must be replaced by a unified system, under state direction, if proper classification according to age, mental condition, and possibilities of reformation can be expected, or treatment that is remedial and economical obtained.

2. "The plant of the State Prison at Charlestown should be abandoned. The State Prison should be transferred from the site at Charlestown to the plant now occupied by the State Farm at Bridgewater, the State Farm to be transferred to the control of the Bureau of Prisons for this purpose.

3. "The Norfolk State Hospital, upon its return to state use, should be retained for the custody, care and treatment of inebriates and drug addicts, taking charge of all cases falling within that group.

4. "The principle of a clearing-house should be adopted in our process of court commitment of all offenders by which

    a. All adult offenders who are found guilty, and who, in the opinion of the court, should go to a penal institution, shall be committed to the custody of the Bureau of Prisons, or other state body dealing with adult offenders, instead of to the separate institutions, as at present.

- b. All juvenile offenders who are found guilty, and who, in the opinion of the court, should go to a school or institution for juvenile delinquents, shall be committed to the custody of the Trustees of the Massachusetts Training Schools, or other state body dealing with juvenile offenders.

5. "The defective delinquent should be identified by a process of examination in the courts, and withdrawn from the community for custodial hospital treatment in accordance with his defective condition, instead of committing him for short-term sentences, as at present, with the certainty that he will repeat his offenses an indefinite number of times.

6. "Present beginnings in the identification and institutional treatment of those feebleminded persons in the community who are a menace to life and property, and are breeders of their own kind, should be extended

- a. By mental examination, by a method approved by the Commission on Mental Diseases, of all persons detained in penal and correctional institutions;
- b. By mental examination, by a method approved by the Commission on Mental Diseases, of all minors admitted to the State Infirmary, and of all women admitted there for confinement;
- c. By mental examination, by a method approved by the Commission on Mental Diseases, of every child intellectually markedly retarded in the public schools;
- d. By a centralized system of registration of all feebleminded, under the direction of the Commission on Mental Diseases;
- e. By the development, under the Commission on Mental Diseases, of a process of supervising feebleminded persons in the community;
- f. By the immediate extension of the Wrentham State School to its contemplated maximum capacity of 1,800 beds;
- g. By the immediate development of the Belchertown plant to a maximum capacity of 1,800 beds."

The report also includes the following specific proposals for legislation:

1. "An amendment to our present laws, providing for the commitment of offenders to a public body in charge of correctional institutions, instead of to the institution itself.

2. "An act transferring the control of the State Farm from the Trustees of the State Infirmary and State Farm to the Bureau of Prisons, and transferring the State Prison from Charlestown to the land and buildings now occupied by the State Farm at Bridgewater.

3. "An amendment to Chapter 595, Acts of 1911, securing a clearer differentiation between the criminal features and the chancery functions of that law.

4. "An act providing for the compulsory mental examination, under the direction of the Commission on Mental Diseases, in all courts of all persons found guilty, who are repeaters, or who are suspected of being mentally deficient, for the purpose of carrying the defective delinquent law into effect.

5. "An act providing for a central system of registration of the feebleminded, under the direction of the Commission on Mental Diseases.

6. "An act providing for the mental examination of all persons committed to penal or correctional institutions, and of all minors admitted to the State Infirmary, and of all women admitted there for confinement.

7. "An act providing for the mental examination of all children of school age who are three or more years intellectually retarded, or who, in the opinion of the school authorities, are mentally defective; such examination to be made in accordance with a method approved by the Commission on Mental Diseases.

8. "An act providing for physical examination of all persons convicted of sex offenses, and authorizing the forcible detention of such as are found diseased, so long as their condition remains a menace to the public health. (No bill is submitted, as legislation is already proposed by others covering this head.)

"Bills embodying the foregoing recommendations are appended to this report."

These conclusions and recommendations for legislation are based upon the commission's careful study of the problems presented by (1) criminals and misdemeanants, (2) alcoholics and drug addicts, (3) defective delinquents, (4) female offenders with venereal diseases, and (5) the feebleminded. The report contains statistical data showing percentages of nervous or mental abnormalities found in inmates of penal and reformatory institutions of Massachusetts and other states, and also other data relative to recidivists in the various penal and reformatory institutions within the state.

The commission was composed of: Dr. Walter E. Fernald, Superintendent, Massachusetts School for the Feebleminded, Chairman; Ellen W. Gray, Chairman, Advisory Board of Prisons; Thomas W. White, Supervisor of Administration; Edward C. R. Bagley, Director of Prisons; Dr. George M. Kline, Director, Commission on Mental Diseases; and Robert W. Kelso, Executive Director, State Board of Charity, Secretary.

Minnesota

Chapter 407, Session Laws of 1919, authorizes the State Board of Control, with the approval of the state auditor, to select from public lands owned by the state a site for a colony for epileptics and a colony for feebleminded persons. Suitable buildings are to be erected upon such lands, and improvements made, as necessary, for the purposes.

The colony for the feebleminded and also the one for epileptics are to be established and maintained under supervision of the State Board of Control. Admission to these colonies will be under the same regulations as prescribed for admission to the School for Feebleminded and Colony for Epileptics, located at Faribault, of which institution these new colonies will be departments.

Missouri

In the summer session, for five weeks beginning June 16, at the Harris Teachers' College, conducted by the St. Louis Board of Education, courses will be offered for the preparation of teachers and examiners of backward and feebleminded children. One course includes manumental and industrial work for the backward and feebleminded, another is devoted to the clinical methods of examining mentally defective children, and a third course is given over to work in mental testing, including practice and observation. It is probable that a demonstration class will also be conducted.

New Hampshire

In accordance with Chapter 14, Public Acts of 1919, the authority over and supervision of the state hospital, school for feebleminded, industrial school, sanatorium for consumptives, and the state prison are vested in the governor and his council. A board of seven trustees is created for each of these five institutions. Five members of each board are to be appointed by the governor and council. The governor and a member of his council whom he appoints constitute the other two members of each board. The boards are to manage the institutions under the supervision and direction of the governor and council. The executive head of each institution is to be chosen by the trustees, subject to the approval of the governor and his council.

Another provision of this act authorizes the governor and his council to appoint a purchasing agent for a term of three years. It shall be his duty to purchase materials and supplies for these institutions, the normal schools, state library (except books and periodicals), and all departments quartered in the state house, except small and miscellaneous articles which the governor and council may authorize the head of any department to purchase. Whenever the commissioners of any county, the trustees of the New Hampshire College of Agriculture and Mechanical Arts, or the Soldiers' Home so desire, he shall purchase materials and supplies for them also.

It will be recalled that in 1917 a law was enacted in this state creating a board of trustees of state institutions for the management of the five institutions mentioned above. The powers and duties of these trustees shall cease upon the appointment of the trustees provided for by the new act.

New York

The so-called "Mental Deficiency Law," providing for a uniform state-wide commitment procedure for the feebleminded, which was summarized in the last issue of MENTAL HYGIENE, passed both houses of the legislature, with minor amendments, and has been signed by the Governor.

A new hospital recently established on North Brother Island, by the Health Department of New York City, will be devoted to the treatment of drug addicts. The hospital has a capacity of 200 beds, and will receive patients committed by the courts as well as self-committed persons who desire treatment.

New buildings which are now being constructed at Letchworth Village will make possible the care of 840 additional patients during the coming year, bringing the population up to about 1,200.

A bill that would authorize the establishment of psychiatric clinics in cities of the first and second classes and also in counties, designed to aid the criminal courts in the examination and trial of persons brought before these courts, failed of passage. It was intended that these clinics should aid the school, health and charity departments and serve other community purposes.

North Carolina

The juvenile court act of 1919, which provides juvenile courts for rural as well as urban populations, contains one section pertaining to the examination and treatment of children found to be mentally defective. The court has the right to cause any child who appears to be mentally defective to be examined by two licensed physicians, and upon their written statement that in their opinion the child is mentally defective, or epileptic, the court may commit such child to an institution authorized by law to care for the mentally defective or the epileptic, as the case may be. No child shall be committed to such institution, however, unless an opportunity for a hearing is given to parents, guardian, or custodian of the child.

A law has been passed by the 1919 legislature authorizing the sterilization of any inmate of a penal or charitable institution or hospital of the state, when in the judgment of the board created by this act the operation would be for the improvement of the mental, moral or physical condition of the inmate. The operation may not be performed until it has been affirmed by the governor and the secretary of the State Board of Health. This law further states: "At least one representative of the medical staff of the several charitable and penal institutions of the state, and one from the State Board of Health, such representatives to be designated by the governing bodies of the several institutions, shall constitute a board of consultation for the carrying out of the provisions of this act. Said board shall cause a permanent record to be kept by one of its members, designated as secretary, of all its actions and judgments, taken at a meeting held only after due notice has been issued to all its members."

Pennsylvania

If House Bill 1141 becomes law, the Eastern Hospital for the Insane, authorized by the 1917 legislature and located at Selinsgrove, will receive an appropriation of $545,000, of which $45,000 is for the purchase of additional land, and $500,000 for the construction of buildings and improvements.

House Bill No. 1055, now in the hands of the Governor, aims to provide special classes for the education of extremely "backward" pupils in the primary grades. It requires every county and every district superintendent to secure information by the first day of October each year as to every child in each district between the ages of eight and sixteen years who because of exceptional physical or mental condition is greatly retarded in school work or who is not being properly educated, and to determine and report to the board of school directors of each district whether such child is a fit subject for special education. Proper education in special classes in the public schools or in special public schools must be provided for children reported to be fit subjects for special training. In case it is not feasible to form a special class with a minimum attendance of ten children in any district, or if for any reason it does not seem best to provide in the public schools of the district such education for any such child, the board of school directors may secure such training outside the school district in accordance with the terms of this act and other acts applicable to the training of such children.

School districts maintaining special schools and classes, approved by the State Board of Education as to location, constitution, size of classes, conditions of admission and discharge of pupils, equipment, courses of study, methods of instruction and qualification of teachers, shall receive from the state an amount equal to one half the total expense incurred in the maintenance of such classes and schools. The same provision is also made in case a board of school directors furnishes such education outside its district.

Tennessee

Chapter 150, Public Acts of 1919, which was approved by Governor Roberts April 15, provides for the establishment, construction and maintenance of the Tennessee Home and Training School for Feeble-minded Persons. This institution is to be constructed on the colony and cottage plan, preferably on lands already belonging to the state.

In addition to the court procedure outlined in the law, provision is also made for admission upon the application of the father, mother, or guardian of the child, or any health officer or school official to the superintendent of the institution, if the applicant judges the child to be feebleminded and if the superintendent finds upon examination that the child is feebleminded. Provision is also made for the transfer to this institution of feebleminded persons now confined in the state hospitals for mental disease.

The superintendent is to be appointed by the Board for the Administration of State Institutions, and must be a graduate of a reputable medical college, of good moral character and with experience in the practice of his profession. Other officers, attendants and laborers are to be selected by the superintendent.

The act requires the segregation of sexes and separate maintenance of white and colored persons and of those convicted of felony.

Another provision reads as follows: "That the superintendent shall cause every person admitted to the institution to have, during the first month of his or her residence, a mental examination. Every person shall have, within the first two years of his residence, a second mental examination, and within the first five years a third mental examination. Case histories of all inmates shall be carefully filed and the following data shall be kept concerning each inmate.

1. "Physical examination

2. "Personal history (what sickness the person has had, at what ages and of what duration)

3. "Family history (nervous and mental diseases and defects in ascent or descent from the person in question and in collateral branches of the family)

4. "Educational history of the person before and after entering the institution (progress in school and other training work)

5. "Industrial history (at what employment has the inmate worked and with what success?)

6. "Civil and social relations (is the inmate married or single; and if a female, has she had illegitimate children? How many? Names? Ages?)

7. "Mental development (specific results of intelligence and other mental tests from time to time. Rating of the person in intelligence and in other essential elements in character formation)."

The act also provides for parole on the part of the superintendent, when he is satisfied that the inmate will be properly cared for and that his parole will not be detrimental either to the inmate or society. The parole must be cancelled and the inmate recalled to the institution whenever the superintendent learns that the welfare of the former inmate or of society requires it. The superintendent also has the power to discharge any inmate who, in his judgment, is not feebleminded.

The sum of $180 per year is appropriated for the maintenance of each person whose support is not otherwise provided for, either from his own property or by some other person. A further appropriation of $10,000 is also made to be used for improvements, general repairs and equipment of property taken over by the Board for the Administration of State Institutions, and to be used for the Tennessee Home and Training School for Feebleminded Persons.

Another section of the act requires that private institutions for the feebleminded must be licensed by the Secretary of State upon the certificate of the Tennessee Board of State Charities. This certificate is issued only after the inspectors of the Board are satisfied that the superintendent is competent to diagnose feeblemindedness and to direct the care and training of feebleminded persons, that he has suitable grounds, buildings, equipment, personnel, etc.

Vermont

A law enacted by the 1919 legislature allows the commitment of women between the ages of 21 and 45 to the school for feebleminded. The commitment law of Vermont hitherto has applied only to children between the ages of five and 21.

An act approved March 14, 1919, allows the transfer of inmates from the industrial school and the school for the feebleminded to the state hospital. This law also authorizes the transfer of a patient from the state hospital to the state school for feebleminded. In each case the superintendent makes application to the State Board of Supervisors of the Insane for an examination of the person to be transferred. If in the judgment of the Board, after such examination, the person should be transferred, the Board notifies the governor in writing. The governor may then order such person transferred.

Washington

House Bill 123, which failed of passage, was designed to create a state commission to have supervision of the treatment of persons with mental disease and the feebleminded; to provide psychopathic wards for persons of curable mental state; to authorize voluntary admissions for treatment; and to create the office of state alienist. Another bill that was not enacted would have provided for special wards at each county hospital, for the care and observation of persons charged with insanity.

Canada

As a result of a survey of Manitoba made by the Canadian National Committee for Mental Hygiene, and in accordance with the Committee's recommendations, a law has been enacted by the Legislative Assembly of Manitoba entitled *The Mental Diseases Act.* Among other provisions is one for voluntary admission to the psychopathic ward of the Winnipeg

General Hospital or to the hospitals for mental diseases of any resident of the province who believes himself to be in need of treatment.

Another section of the act reads as follows: "Any person apparently insane and conducting himself in a manner which in a sane person would be disorderly may be apprehended without warrant by any peace officer or constable and brought to a justice of the peace or to two qualified medical practitioners who shall thereupon respectively deal with such person as in this Act provided in the case of other persons brought before them with the object of their being sent to the psychopathic ward or to one of the said hospitals."

By this act "The Selkirk Insane Hospital" becomes "The Selkirk Hospital for Mental Diseases" and the name of The Brandon Insane Hospital is similarly changed.

A section of the act designed to assist in making a census of the mentally defective or diseased is as follows: "Each municipal assessor shall, when making his assessment under *The Assessment Act*, ascertain and enter upon a blank prepared for that purpose and furnished by the clerk of the municipality the names and surname in full of all insane or idiotic persons in his assessment district not confined in a hospital, and the age, sex, occupation and place of birth of each of such persons and return the same to the clerk of the municipality at the time of completing the assessment roll for said district, and the clerk of the municipality shall, on receipt of the said roll, transmit such return to the Department of Public Works."

The law provides for the discharge of patients by the superintendent of the hospital.

The Lieutenant-Governor-in-Council may make rules and regulations for the management of the psychopathic ward and of each hospital. He may also appoint a medical superintendent for each hospital and the psychopathic ward, and such other officers as are required. He may from time to time, in case of necessity, authorize the temporary use of any buildings as hospitals for mental diseases.

Legislation for Defective Children in Missouri

The first Missouri Children's Code Commission, appointed by the Governor in 1915, submitted 42 bills of which ten were enacted into law by the 1917 legislature. The second Commission, appointed by the Governor in 1917, secured favorable action in the 1919 session on 25 of the 51 bills which were introduced. Plans are already being considered for the formation of a third Commission and for the reintroduction, in the 1921 session of the legislature, of the bills which failed. Only such bills will be referred to here as were introduced by the Children's Code Commission in the interest of defective children.

The new compulsory attendance law requires full-time attendance throughout the state of children between 7 and 16, unless they have completed the eighth grade at 14 or 15. The act applies to the feebleminded, deaf, blind and crippled children where special classes have been provided for their instruction.

The establishment of special classes for the feebleminded, blind and deaf (the crippled were eliminated) is made mandatory in every school district in which there are ten or more children of each type. Moreover, "where two or more school districts each have less than ten children in each of these types, the boards of education of such school districts may contract with each other for the establishment of special classes . . . provided the pupils cannot be accommodated in the appropriate state institutions." Where no special classes have been provided, the State Board of Charities and Corrections is authorized to "provide for the proper training of feebleminded, deaf, and blind children under the age of sixteen years who have not attained the eighth grade in school." Where the parent or guardian is unable to bear the expense, the cost may be charged to the county in which the child resides. State aid is granted to the amount of $750 per year for each teacher wholly employed in any of these classes, provided she has received special training for the work "in accordance with the rules and regulations established by the state superintendent of public schools," and provided the amount of state aid shall not exceed two thirds of the salary paid the teacher by the local board. In New York and New Jersey the establishment of special classes for mentally retarded pupils is also compulsory. The acts in these states apply only to children retarded three or more years, and are so drawn that the classes will inevitably consist of both feebleminded and backward children.

The supervision of the instruction and the "designation of courses of study and necessary equipment" in all state schools for children is vested in the state superintendent of instruction: the schools for the deaf, blind, feebleminded and epileptic, and the girls' and boys' training schools and reformatories. It is also the "duty of the state superintendent of schools to examine teachers for the above-named institutions and grant certificates of qualification to those who pass a satisfactory examination. Only persons holding said certificates from the state superintendent of schools shall be employed as teachers in the above-named institutions." In only two or three other states in the Union is the instruction in institutions for the feebleminded placed under the chief educational officer of the state.

The commitment of the dependent, delinquent, criminal, immoral feebleminded is made compulsory after due process of petition, court hearing and certification by a "competent psychologist or competent physician, and no person shall be committed without a certificate of such psychologist or physician or a majority thereof." The persons contemplated by the Act are defined as follows: "The words 'feebleminded person' shall be construed to mean any person afflicted with mental defectiveness from birth or from an early age, so pronounced that he is incapable of managing himself and his affairs and of subsisting by his own efforts, or of being taught to do so, and who requires supervision, control, and care for his own welfare, or for the welfare of others, or for the welfare of the community, and who cannot be classified as an 'insane person.'" This definition substantially corresponds to the definition in the English Mental Deficiency Act of 1913—which displaces the definition of the English Royal Commission—and is also practically the same as the Illinois Commitment Act of 1915. It will be observed that all of these definitions are based on social considerations, without any attempt to define feeblemindedness in terms of an arbitrary age-level, as in the California Act, according to which the feebleminded "will not develop beyond the level of the average child of twelve years."

The act for the enlargement of the colony for the feebleminded and epileptic provides, "as soon as the funds therefor are available," for the segregation of the epileptics into separate colonies, for the segregation into "separate colonies or institutions or if this is impossible, then into separate wards or detached cottages, of all feebleminded delinquents, prostitutes, children and other classes of inmates, who for their own welfare or for the welfare of other inmates should be segregated," for the establishment of "a separate cottage or cottages for the colored inmates," and for the establishment of "other colonies in temporary or permanent camps, in connection with the central colony at Marshall, at any place or places in the state where the inmates may be profitably employed and their welfare better secured." Unfortunately the fruits of this advanced legislation with respect to the commitment and colonization of the feebleminded cannot be immediately reaped because of the inability to secure funds for the enlargement of the colony, which now contains less than 600 inmates while the number on the waiting list has for several years been considerably larger. The appropriations voted by the legislatures in 1915 and 1917 were vetoed by the governors because of the failure of the legislatures to provide the revenues.

The bill for the prevention of the marriage of the "insane, mentally imbecile, feebleminded and epileptic," was defeated by both houses, while the bill for the establishment of a State Bureau for Mental Defectives which was passed by the House, was lost in a Senate filibuster, which was responsible for the defeat of thirteen other bills passed by the House.

THE ILLINOIS SOCIETY FOR MENTAL HYGIENE

The Illinois Society for Mental Hygiene has been reorganized and has adopted a new constitution and by-laws designed to extend the activities of the Society throughout the state. The officers are to consist of a president, not more than three vice-presidents, a treasurer and a secretary, and are to be elected by the board of directors. This board is to consist of not more than sixty members of the Society to be elected by a majority vote at the annual meeting and to serve four years. This board is also to appoint a committee of four to act with the president as an executive committee.

The officers of the Society are as follows: Anna Hamill Monroe, President; Harry Olson, Mary H. Wilmarth, Sidney D. Wilgus, M.D., Vice-Presidents; John S. Broeksmit, Treasurer; and Mrs. George Deane, Secretary.

The members of the Executive Committee are: H. Douglas Singer, M.D., Chairman; Sydney Kuh, M.D.; Cyrus McCormick, Jr.; Mary Rozet Smith; and Anna Hamill Monroe (*ex officio*), Secretary.

The Executive Committee has adopted rules which include the employment of a full time medical director and the subdivision of the activities of the Society into two departments (1) Social Service (2) Henry B. Favill School of Occupations, each with a superintendent and such workers as are necessary.

THE NEW YORK SCHOOL OF SOCIAL WORK

The New York School of Social Work, formerly called the New York School of Philanthropy, offers a summer session, from July 7 to August 15. This session is planned for teachers, ministers, nurses, and other professional workers, students in theological schools, volunteers, social workers who may wish to concentrate on technical problems in their particular field of work, college seniors and those who may wish to obtain advance credit on entering the School as regular students. One of the courses offered is in social psychiatry and is conducted by Dr. Bernard Glueck. It will include a discussion of the prevalence and social bearings of insanity, feeblemindedness, epilepsy, and neurotic conditions, with particular reference to social control and relief. Case histories will also be studied in connection with this course.

MENTAL HYGIENE CONFERENCE CENTER

As the result of the need expressed by Associations, social workers and others for a place where persons with mental maladjustments of the less pronounced degrees may receive attention without the implication of seriousness which a hospital often arouses, the National Board of Young Women's Christian Associations has opened a Conference Center to which women and girls may be referred for advice and treatment. It is expected that the majority will be received from medical or social sources, but the Center is available for women and girls referred in any way.

The value of the work will depend to a large degree upon the cooperation of the agent who refers the case. The Center does not plan, except in a very limited degree, to institute social service mechanisms but to work whenever possible with those already existing.

The Center is located at 313 Flatiron Building, New York City. The staff includes Alberta S. B. Guibord, M.D., Mabel R. Fernald, Ph.D., Anne T. Bingham, M.D., and Almena Dawley.

CANADIAN JOURNAL OF MENTAL HYGIENE

Persons whose interest or whose work brings them into contact with mental problems will welcome the new *Canadian Journal of Mental Hygiene*, the first number of which has recently been issued. This publication has the same scope and aims as MENTAL HYGIENE and will contain articles which are non-technical in nature, reports submitted by recognized authorities, and other material designed to interest and instruct the Canadian public in the field of mental hygiene. The following articles are published in the April, 1919 number: *The Function of a Psychopathic Hospital*, by E. E. Southard, M.D., Director, Psychopathic Department of the Boston State Hospital; *The Scope and Aims of the Mental Hygiene Movement in Canada*, by C. M. Hincks, M.D., Associate Medical Director and Secretary, Canadian National Committee for Mental Hygiene; *The Story of the Toronto General Hospital Psychiatric Clinic*, by C. K. Clarke, M.D., LL.D., Medical Director, Canadian National Committee for Mental Hygiene; *Some Remarks on the Neuroses of the War*, by H. P. Wright, M.D., Major, C.A.M.C., Montreal; *Immigration, Past and Future*, by W. G. Smith, B.A., Professor of Psychology, University of Toronto; *Immigration and the Canadian National Committee for Mental Hygiene*, by J. D. Pagé, M.D., Major, C.A.M.C., Chief Medical Officer, Port of Quebec; *Social Service and Mental Hygiene*, by R. M. MacIver, D.Phil., Professor of Political Economy and Acting Director, Department of Social Service, University of Toronto; *Subnormal Intelligence as an Educational Problem*, by Peter Sandiford, M.Sc., Ph.D., Professor of Psychology, Department of Education, University of Toronto.

An account is also given of the purposes and activities of the Canadian National Committee for Mental Hygiene, showing the work that has been accomplished by the Committee during the first year of its organization. A brief account of the mental hygiene survey in Manitoba and recommendations to the Manitoba Government are presented. An interesting foreword in the form of an editorial, showing the nature of the problems in Canada and the purposes of the Committee and its publication, precedes the articles, and the final pages of the magazine are devoted to notes and news items.

COURSES IN SOCIAL WORK AT THE UNIVERSITY OF TORONTO

The Department of Social Service of the University of Toronto has recently issued an announcement of its extension courses to begin April 21. The courses are arranged with two objects in view, one course being intended especially for those who wish to enter the field of mental hygiene. This course is being given with the aid and at the request of the Canadian

National Committee for Mental Hygiene and is designed to give in a short period such initial training as will enable the student to meet the problems of social service in this field. A second course is intended for those who are unable to take the regular course of the department, but who wish to have some special training in social work. Instruction will be given in psychiatry, social and economic problems, neurology, mental tests, case work, social institutions, occupational therapy, child welfare, home economics and recreation.

Visits of inspection will be made to institutions and agencies in and near Toronto and a minimum of ten hours per week in the work of the psychological clinic of the Invalided Soldiers Commission will be required. Additional information may be had upon application to the Secretary of the Department of Social Service of the University.

MENTAL HYGIENE CLINICS AND HEALTH CENTERS

Dr. Walter B. James, formerly Chairman of the New York State Commission for the Feebleminded, in a recent number of *Health News*, the monthly bulletin of the New York State Department of Health, writes as follows:

The proposal of the State Department of Health to establish health centers throughout the state, in order to furnish to the people of the small cities and the country districts aid in the maintenance of health which is not now to be had, marks a distinct advance in our view of the duty of such a department to the public.

The following suggestions are made with a view of widening the usefulness of such health centers and of securing even broader health service to the people of the state. The Department of Health is not alone in being concerned with state health problems, there being many other divisions of the government which are almost equally interested. The importance of mental health as well as its relation to bodily health is daily becoming more and more widely recognized.

There is a universally admitted need throughout the state for an extension of the opportunity for having mental examinations made of persons whose intellectual soundness is suspected. This need is felt by at least seven important state agencies: The State Hospital Commission, the State Commission for the Feebleminded, the State Department of Health, the State Department of Education, the State Commission of Prisons, the State Probation Commission and the State Board of Charities with its numerous affiliated associations.

In addition to these state agencies, there are closely affiliated private organizations which also have a very direct interest in the establishment of such clinics, especially the State Charities Aid Association, which has already done a great deal of most valuable clinical work along this line and which has stimulated the establishment of mental clinics by the State Hospital Commission.

The State Hospital Commission now has between twenty and thirty clinics, many of which are doing successful work, but these are not extensively or generally used by the other agencies above mentioned and it seems unlikely that they will be so used unless the remaining state departments can have some part in and some responsibility for them.

The present plan for state mental clinics, therefore, proposes a board of joint control, to consist of one of the leading officers of each of the above mentioned seven agencies. This board has already been formed at a meeting at which all of the organizations were represented. It is proposed that it encourage the creation of clinics throughout the state wherever they may be found to be needed. It is intended that, for the most part, the clinics shall be maintained by local agencies already existing, such as hospitals, dispensaries, county boards of child welfare and others.

Thus it is clear that this plan is merely an extension of the health center scheme which is being developed by the State Department of Health. This department had already considered having a room for mental hygiene in connection with the various health centers and it is possible, indeed, that it may seem wiser to drop the name "mental clinic" and in each case merely to call the agency a "health center" and to develop gradually in each such center all of the activities that can be made of value to the inhabitants of the district. It is not intended, and this should be clearly understood, to establish departments of medicine and surgery, or to furnish a substitute for the medical and surgical advice that is already adequately provided throughout the state by practitioners of medicine, but rather to cover ground which at present is not covered, especially in the abnormalities of the mind.

Special services will be furnished from the staffs of the State Hospitals for the Insane, from the State Commission for the Feebleminded, the Board of Education and the State Board of Charities and its institutions, and the State Department of Health. It is believed that in this way a maximum of service to the people of the state can be had at a minimum of cost through the utilization of agencies already existing. It is the intention of the board of control to begin with the creation of such clinics in five or six selected towns, where immediate cooperation and interest can be had, and it is hoped and believed that from this beginning a state-wide system can be gradually developed.

It has been thought best that at the outset the Board of Control of Mental Clinics, or, as it may be called in the future, of "Health Centers," should be informally created and not by act of legislature. Later, it may seem best to make it a matter of legislative enactment.

The idea of such a clinic is not a new one, as it already exists in an admirable form at Waverley, Massachusetts, where it is conducted by Dr. Fernald, head of the institution for the feebleminded. The present plan proposes to make the invaluable services of such a clinic as Waverley available to as many as possible of the citizens of the state.

Such a clinic would naturally operate somewhat as follows: There would be a fixed day when patients could be brought for preliminary study, when the various mental tests would be made, the history taken, perhaps a physical examination made and when an inquiry into the environment of the patients could be started. On a subsequent date, a few days later, the patients would be again brought to the clinic, when the State Hospital psychiatrist especially chosen and fitted for such work, and who would be at the head of the mental division of the center, having all of the above data prepared and recorded, would make a diagnosis, arrive at a conclusion, put the patient upon rational treatment and give the wisest counsel.

It is believed that such a system would provide as widely as possible for the citizens of the state the benefits of the best modern knowledge of mental disorders which are not available today. The experience of the new American army in relation to psychiatry and the valuable facts and principles that have been accumulated through the labors of the psychiatric division of the army, have made it even more evident than it was previously, that great benefits can be made to accrue through the early detection and the skillful management of the mental disorders and abnormalities and maladjustments that are so common throughout the community.

The plan, as outlined, contemplates cooperation between a number of distinct and independent state mechanisms and the utilization in common of the resources of these for the attainment of a common aim. This is a principle which may be somewhat new in governmental relations, but it has so much to commend it that it seems more than worth while to attempt a successful accomplishment.

Mental Defectives in Indiana

The second report of the Indiana Committee on Mental Defectives has recently been transmitted to the Governor. The first report, it will be recalled, was presented in 1916. This second report comprises a survey of eight counties which are representative districts of Indiana. The purpose of the study was to determine first, where; second, of what type; third, how dangerous to the community; and fourth, how many are the mental defectives in Indiana. The following were the sources of information of the investigators: physicians, school authorities, township trustees (overseers of the poor), persons or organizations interested in community welfare, state records of charitable and correctional institutions, county clerks' records, county judges and county prosecutors.

In this survey the term mental defective includes the insane, the epileptic and the feebleminded. "An insane person is one incapacitated as the result of a mental disease." An epileptic is defined as "a person subject to 'falling sickness,' or periodical convulsive seizures, generally called epilepsy." Feeblemindness is defined as an "arrest of development somewhere between infancy and twelve years of age. It may be defined as a 'state of mental defect existing from birth or an early age, and due to incomplete or abnormal mental development, in consequence of which the person afflicted is permanently incapable of performing his duties as a member of society in any position.'" The classification of feebleminded into idiot, imbecile and moron is also presented.

After a discussion of the data for each of the eight counties, the following topics are treated: Mental Defectives and School Children; Relation of Mental Defectiveness to Pauperism; Mental Defectives among Dependent Children; Mental Defect in Relation to Delinquency and Crime; and Defectives in the Community. A few histories of individuals and also of families are presented, illustrated by charts.

The following conclusions are presented:

1. "Existing social conditions are complicated by the presence of defectives in the community.

2. The value of reconstruction plans for the future will be discounted by the defectives employed by our industries and by those forced into idleness because of unfitness.

3. Education of the public regarding the facts relative to mental defect is necessary to the solution of the problems arising therefrom.

4. The counties studied in the survey were selected because they represented communities typical of Indiana for location, resources and industries.

5. At a conservative estimate, 2.2 per cent of the general population is mentally defective, i.e., either feebleminded, insane or epileptic. On this basis Indiana has 59,419 defectives.

6. Of these 59,419 defectives, 5,192 are in the state hospitals for the insane; 1,409 are in the School for Feebleminded Youth, and 348 are in the State Village for Epileptics.

7. On the basis of the percentage obtained from the eight counties, Indiana has in the community, outside of public institutions

20,526 feebleminded needing institutional care.
20,796 feebleminded not needing institutional care.

Total 41,322 feebleminded in the community.

Of our feebleminded now needing institutional care 6.4 per cent are in the School for Feebleminded Youth at Fort Wayne.

8. On the same basis, Indiana has in the community outside of the five hospitals for the insane

1,482 insane persons needing institutional care.
1,593 insane persons at present not needing institutional care.

Total 3,075 insane in the community.

Of our insane now needing institutional care 78 per cent are in the state hospitals for insane.

9. On the same basis Indiana has in the community outside of the State Village for Epileptics

1,296 epileptics needing institutional care.
2,538 epileptics not needing institutional care.

Total 3,834 epileptics in the community.

Of our epileptics now needing institutional care 21 per cent are at the State Village for Epileptics."

The committee recommends:

1. The enlargement of the Village for Epileptics and additional provision for the care of women at this institution.
2. Increased accommodations for the insane.
3. The construction, in connection with the state hospital for care of medical and surgical cases, of a psychiatric department for observation and treatment of incipient mental cases.
4. The establishment of detention wards at other general hospitals for observation and detention pending commitment and admission to the state hospitals.
5. A law providing for voluntary admission to and temporary detention in state hospitals.
6. Additional provision in the way of farm colonies for feebleminded.
7. A law providing for commitment to the School for Feebleminded Youth, the same as to the Village for Epileptics.
8. Mental examinations of school children.
9. Free mental clinics in connection with the state hospitals, and the state institutions for the feebleminded and the epileptic.
10. A law to prohibit confining insane, feebleminded or epileptic in any county jail pending admission to a state institution.
11. Development of occupational therapy for patients.
12. Prevention of mental defect, (a) through the officials of the state assisting in the operation of the Federal anti-vice laws; (b) by their helping in the operation of the Harrison law limiting the use of drugs; (c) by keeping Indiana as dry in fact as in theory; (d) by enactment of laws declaring the mental age as the legal age; (e) by requiring of physicians in their application for licenses a more technical knowledge of nervous and mental disease and mental defect, and by making provision for the adequate education of medical students and physicians in these subjects.
13. The enactment of a law providing for the continuance of a commission to study the entire question of mental defectives in Indiana.

In a recent number of *Flying*, Major R. W. Schroeder, U. S. A., A. S., gives a striking account of how he attained the world's altitude record. One of the most interesting features of Major Schroeder's story is the description of his sensations and altered judgment when at the high altitude. Major Schroeder writes:

"In order to take an aeroplane to a higher altitude than any other pilot in the world, I found that it would require more than one or two attempts. I made three attempts. The first one took me to an altitude of 24,000 feet, the second to 27,000 feet and the last one to 28,900* feet; but now I feel certain that with a few changes and improvements, I can get to 30,000 feet or better.

"The altitude reached is only 102 feet short of the highest mountain peak in the world, the great Himalaya peak, which is 29,002 feet high. Most people cannot stand high altitudes, and from 10,000 to 15,000 feet they bleed at the nose and ears. I had been to 12,000 feet at different times and experienced no difficulties. After being put in charge of the Testing Squadron at Wilbur Wright Field, my duties required me to go to the ceiling with all new types of high-powered battle aeroplanes, which were being experimented with by the United States Government. (By ceiling, I mean the highest altitude that the aeroplane can reach.) During these trips I would quite often go without the use of oxygen, and in time I discovered that I was becoming accustomed to the rare, thin air. However, I did not seem to be able to go above 23,000 feet at any time without feeling a sort of sleepy, tired, cross and hungry feeling, which I was unable to overcome except by the use of oxygen. Without the use of oxygen at these altitudes, I would feel that I was doing everything just right, and even if the aeroplane would get into some critical position and I could see when I looked down that the earth that should be underneath me was not there any more, but was way over on the other side of the machine, yet I believed that I was flying all right, and that my flying position was right, but the earth was in the wrong place. So after having these experiences, I decided that I would have to overcome these dangers, and the way I did it was to keep my mind on one thing; and that was, when the earth is in the wrong place, use oxygen. This I did, and found that it worked out very well.

"The cold, thin air is one's great adversary. First of all, one must make a study of the performance of his motor at these high altitudes. This I did, and made the necessary changes each time before trying again. A very positive oxygen regulator and face mask should be used. These were unobtainable, for the sets I had previously tried out had failed to function above 21,000 feet. Furthermore, the face mask pressed so tight to my face that it interfered with the flow of blood and my face grew numb, so I used a rubber hose direct from the oxygen bottle, which I regulated with a valve on the bottle. The hose was placed in my mouth so that I could breathe air and oxygen at the same time. I also pressed my tongue against the end of the hose in order to tell if the oxygen was still flowing. This method was very satisfactory, except that the oxygen bottle and the rubber tube gathered about a quarter of an inch of frost, which made it very unpleasant.

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* This height has recently been exceeded.

"The following experiences and sensations I noticed during my flight were due to lack of oxygen. I took off at 1:45 p. m., Wednesday, September 18, 1918, and made a steady circular climb, passing through clouds at 8,000 feet, 12,000 feet and 16,000 feet. While still climbing in large circles my goggles became frosted, making it very difficult for me to watch my instruments. The temperature at this altitude was two degrees below zero, centigrade. When I reached 25,000 feet I noticed the sun growing very dim, I could hardly hear my motor run, and I felt very hungry. The trend of my thought was that it must be getting late, that evening must be coming on and that was the reason the sun was getting so dim. But I was still climbing, so thought I might as well stick to it a little longer, for I knew I could reach my ceiling pretty soon, then I would go down and, even though it were dark, I could land all right, for I had made night landings many times before; and so I went on talking to myself, and this I thought was a good sign to begin taking oxygen, and I did. I was then over 25,000 feet and the temperature was 60 degrees centigrade below zero.

"As soon as I started to inhale the oxygen the sun grew bright again, my motor began to exhaust so loud that it seemed something must be wrong with it. I was no longer hungry, and the day seemed to be a most beautiful one. I felt like singing with sheer joy as I gazed about through the small portion of my goggles, which had no frost, due to a drop of oil which had splashed on them from the motor.

"It was wonderful to see the very clear blue sky with the clouds thousands of feet below. The frost on my goggles bothered me very much. At times I had to remove my glove in order to put the warm palm of my hand on the glass to thaw the frost. I did this every few minutes so that I could take the proper readings of the instruments, which I marked down on my data pad. I believe that if my goggles had been better ventilated they would not have frosted. When I was about 27,000 feet, I had to remove my goggles, as I was unable to keep a steady climb. My hands by this time were numb and worried me considerably. The cold, raw air made my eyes water and I was compelled to fly with my head well down inside the cockpit. I kept at it until my oxygen gave out, and at that point I noticed my aneroid indicated very nearly 29,000 feet. The thermometer showed 62 degrees below zero, centigrade. The lack of oxygen was affecting me and I was beginning to get cross, and I could not understand why I was only 29,000 feet after climbing for so long a time. I remember that the horizon seemed to be very much out of place, but I felt that I was flying correctly, and that I was right and the horizon was wrong.

"About this time the motor quit, I was out of gasoline, the propeller stopped and everything was quiet, so down I went in a spiral. When I had descended to about 20,000 feet I began to feel much better, and realized that the lack of oxygen had affected me. I passed down through the clouds at 16,000 feet, and, as I remember, it was snowing from these clouds upon the next layer, some 4,000 feet below. I am not positive as to this, as I may have been affected by the lack of oxygen. I noticed as I descended that the air seemed to be thick and stuffy, but very nice and warm.

"During the entire trip I did not see the ground, from the time I went up through the clouds above Dayton, Ohio, until I came down through the clouds again at 4,000 feet above Canton, Ohio, over 200 miles from where I started.

"I was lost, beyond a doubt, with a dead engine, over very rough country. I landed O. K., but broke the tip of my propeller, which was standing vertical, when I rolled into a depression in the ground. However, I did not nose over or do any other damage to the aeroplane or myself.

"My hands and face were numb, my lips and four of my fingers were frozen and required medical attention. Electrically heated clothing would have been very well used, but I dressed as light as possible to avoid the extra weight, as I had stripped the entire aeroplane of all unnecessary load. This was done to assist me in climbing.

"Two barographs were arranged in the aeroplane, which recorded the climb on a small paper drum. I also had a thermometer out on the wing strut, which showed the temperatures. The two barograph papers and the temperatures were sent to the officials of the Aero Club of America, who called a meeting of their Board of Governors, and the result of their meeting gave me an official world's altitude record of 28,900 feet. The Club has sent notification of this record to the International Aeronautic Federation and to the Pan-American Aeronautic Federation, so that the record will be recognized by all the aeronautic bodies all over the world."

MILITARY HOSPITAL FOR MENTAL DISEASES

A new military hospital for mental diseases is to be established at London, Ontario. The plan calls for six ward buildings and one administrative building. This hospital is intended primarily for patients with war psychoses rather than war neuroses.

WAR NEUROSES

Editorial, *Boston Medical and Surgical Journal*

An article of unusual interest, considering with intelligence and insight the condition of war neuroses, has appeared recently in the *Atlantic Monthly*. The author, Frederick W. Parsons, remarks that we have all heard stories, especially at the beginning of the war, of the queer behavior manifested by men who have been exposed to particularly violent bombardment; the term "shell shock" became popular, and was soon applied to almost any unusual mental or nervous condition. This article considers the psychological aspects of the development of war neuroses, pointing out that the symptoms of war neuroses are not essentially different from peace-time neuroses, although they may assume slightly different forms because of the environment of war. The psychological principles of Freud are believed to be important in the production of peace-time neuroses; the individual, unable to adjust himself to a difficult situation, escapes by an unconscious avenue. In war neurosis also, the results of a true neurosis are never conscious and voluntary. Although the causes of war neuroses are many, the foundation of the condition may be traced usually to a difficult situation, whether it be lack of courage, association with uncongenial natures, a sense of injustice; or brooding over real or fancied wrongs. This internal mental conflict, added to poor sleeping, exposure, perhaps hunger, and the explosion of a shell near by, often result in a state of unconsciousness, sometimes followed by blindness, deafness, and loss of voluntary control over the motions. It is a mistake, however, to attribute these conditions to the shell explosion alone. They are the outcome of maladjustment in war as in peace.

The author of this article depicts also the attitude of the psychoneurotic individual who enjoys his neurosis greatly more than the life which caused it, and therefore clings to his symptoms. Either an oversympathetic attitude or neglect may end in making permanent invalidism a result of what should be only a passing phase. An intelligent and sympathetic understanding on the part of the public will greatly benefit men who are returning to this country suffering from war neuroses.

A Layman's Account of the Prevention of War Neuroses

In a series of published articles in *Collier's* on the Meuse-Argonne offensive, Arthur Ruhl, the war correspondent, speaks of the work done in an American Field Hospital to prevent the fixation of war neuroses. His reference brings out so clearly the task of the division psychiatrist during combat that we reproduce the following paragraphs:

"An inspector, experienced in nervous disorders, sorted them at the door—for in the hurry of the aid stations 'shock' is almost as easy a diagnosis as 'gas'—and admitted only those who could not be taken care of elsewhere.

"'What's wrong with you, my lad? Wounded? No? Gas? You're all right—just tired out, that's all. We'll give you something hot and a place to sleep, and in a couple of days have you back with your company.' This 'back with your company' idea was accented at once. The notion of the interior and a long period of convalescence was not, if it could be prevented, permitted to get a start. Even men quite unstrung were treated—if not wounded and able to stand it—in the same heroic fashion. The idea was to get the paralyzed machine functioning normally as soon as possible—not to let the soul sickness become chronic.

"One boy came in trembling like a terror-stricken horse and jerking his hands and arms. He had almost lost the power of speech. 'What's your name, son?' the doctor demanded briskly. The boy stared wildly into space and made no reply. 'What—is—your—name?' repeated the doctor severely. 'Come, come, you've got a name!' The boy pulled himself together and exploded, rather than answered: 'Johnson!' 'What's your other name? You've got a first name. Come—out with it!' The boy made another effort, and finally articulated 'William!' The doctor went on from question to question—not because the information was of any importance, but merely to get the machine running again. An hour later the same man stood in line with a lot of others, waiting for 'chow' and coffee—not quite himself again, for he started when anyone came up behind him, but talking with the man next to him and well on the way."

Care of Compensable Insane by the Federal Government

By order of the Secretary of War, the following circular (225), issued under date of April 30, 1919, outlines the procedure with reference to treatment of the compensable insane soldiers after their discharge from the Army.

1. The Bureau of War Risk Insurance is charged by law with the duty of caring for the compensable insane of the military service after their discharge from the Army, and has undertaken to provide institutional treatment after discharge for cases requiring it. Such cases are to be turned over directly to the care and responsibility of the Bureau in such a manner that there will be no interval between discharge from the military service and the commencement of the continued care in hospitals near their homes which is to be provided by the Bureau.

2. In order to accomplish this, the following procedure will be observed:

a. Cases which have been under treatment in military hospitals in this country for four months, and which are considered to be incurable or to require a much longer period of hospital treatment to effect a cure, will be reported in writing by the commanding officer of the post, camp or station directly to the Chief Medical Adviser, Bureau of War Risk Insurance, Washington, D. C. (attention Section of Nervous and Mental Diseases), who will give instructions as to the disposition desired by the Bureau of War Risk Insurance. When reporting cases to the Bureau of War Risk Insurance under this paragraph, the following information regarding the soldier will be furnished: (1) name, rank, organization, Army serial number and race; (2) length of service; (3) legal residence; (4) name and residence of nearest relative; (5) diagnosis; (6) brief summary of medical history; (7) prognosis.

b. Upon receipt of instructions from the Bureau of War Risk Insurance, the soldier will be ordered discharged on certificate of disability by the authority designated to order discharge in such cases. The same procedure as to preparation and disposition of records will be followed as outlined in Army Regulations governing the discharge of insane in the military service and their delivery to institutions. The soldier will be delivered to the designated institution accompanied by necessary attendants and not discharged until his arrival thereat. When the soldier has been delivered to the authorities of the institution designated to receive him, the senior attendant will ordinarily telegraph the commanding officer authorized to discharge the soldier. Upon receipt of this information the soldier will be discharged and discharge papers mailed to the authorities of the institution to which the soldier was transferred for delivery to the soldier. When a patient is delivered to an institution and discharged, the Bureau of War Risk Insurance will be so informed in writing by the commanding officer concerned.

3. This circular does not in any way amend subparagraph *a*, Circular No. 188, War Department, 1918, relative to the discharge of a certain class of patients who possess funds or have relatives or friends who can afford them specialized care after discharge.

Lieutenant-Colonel E. G. Zabriskie, of New York City, has been designated Senior Consultant in Neuropsychiatry for the American Expeditionary Forces, succeeding Col. Thomas W. Salmon, who has returned to the United States. Lieutenant-Colonel Zabriskie went to France as divisional neuropsychiatrist of the Fourth Division. Subsequently he was consultant in neuropsychiatry to the Third and Fifth Corps and the First Army. After the armistice he served as consulting neuropsychiatrist to the Savenay hospital center.

LIBRARY NOTES

A growing interest in mental health problems is evidenced by the unusually large number of requests for literature and information that have been received by the Library of the National Committee for Mental Hygiene during the past three months.

Among new bibliographies compiled by the Library and available for distribution in limited quantity are: *List of Correlative Reading for the Training School of Psychiatric Social Work at Smith College; Literature on Careers of Mental Defectives; References on Industrial Psychology; Selected References on the Relation of Mental Disease and Defect to Delinquency*—a former bibliography brought to date; *Selected References on Child Training and Psychology; Reading List for Psychiatric Social Workers.*

Over one hundred new books and nearly 600 reprints and pamphlets on psychiatric, neurologic and social subjects have been added since the beginning of the year to the Library's collection of literature. These books and most of the pamphlets may be loaned to persons interested in the field of mental hygiene, who can present proper references, and a collection of more than one hundred sets of periodicals is available for reading and research in the Library.

A new periodical, *The Journal of Industrial Hygiene,* issued its first number in May. It promises to be a journal of unusual interest and value to the field of industrial medicine. The Editors are David L. Edsall, A. F. Stanley Kent; Honorary Consulting Editor, Thomas M. Legge; Associate Editors, W. Irving Clark, Jr., Alice Hamilton, Emery R. Hayhurst, Yandell Henderson, William H. Howell, Frederic S. Lee, Harry E. Mock, J. W. Schereschewsky, C.-E. A. Winslow; Managing Editors, Cecil K. and Katherine R. Drinker. The magazine is published monthly by The Macmillan Company. An especially noteworthy feature is the Supplement entitled *Abstract of the Literature of Industrial Hygiene.* About two hundred periodicals, including foreign publications, will be examined systematically for material pertinent to the subject of industrial hygiene. This list of periodicals to be abstracted will be constantly extended to include foreign publications that are being revived after suspension during the War. The abstracts are classified under headings indicating the subjects treated. Another feature of interest in the May number is the scholarly article entitled *The Problem of Fatigue* by Reynold A. Spaeth, Associate in Physiological Hygiene in the School of Hygiene and Public Health, Johns Hopkins University. This article is supplemented by a very inclusive and valuable bibliography of the subject of fatigue and its effects.

ABSTRACTS

THE RELATION OF THE PSYCHIATRIST TO THE GENERAL PRACTITIONER

By C. Macfie Campbell, M.D. *Maryland Psychiatric Quarterly*, 8: 59–64, January 1919.

The general practitioner of today does not hesitate to appeal to the specialties when he desires aid, but at present psychiatry is a branch of medicine probably less known to him than any other. The indications that a psychiatric examination is necessary are not so clear to him as are those, for instance, demanding a laboratory examination of fluids of the body or an eye examination, etc. He is apt to consider so-called "mental symptoms" as having no bearing upon the physical condition. He, therefore, omits to consider how the case might look if the psychiatric data were taken into account, and is likely to ignore the fact that the key to some symptoms is to be found only by this approach.

The general practitioner is apt to disregard the connection between mental processes and the activities of the whole system. It must be remembered that "we think with our glands as well as with our head." Thought may be used as a term to denote an aspect of the process of adjustment to environment, but in adjustment the whole mechanism of the patient is involved.

Patients may show their emotional reactions in different organs. For instance, a middle-aged woman had suffered for years from stomach trouble; she had acid stomach, much gas, and could not digest her food. But a thorough examination of her digestive apparatus by an internist showed no basis for her chronic invalidism. The real trouble lay in the fact that she could not digest the presence of a rival in her house and "in her emotional reactions gastric symptoms were apt to be rather prominent."

The psychiatrist studies these reactions of the patient. When an ordinary medical examination shows no basis for the symptoms the internist frequently suspects more complex factors such as the psychiatrist deals with, but when he finds a physical basis for the symptoms he is frequently content to ignore the possibility of more complex contributing causes.

The author gives examples of sciatica as a result of family friction. The symptom of headache is one of the most common in response to difficult situations. Some people have a constitutional tendency to recurrent headache. These two factors may combine in the individual case.

"One patient herself commented on the fact that she had no headache on the afternoons when there was the weekly party; another patient, from a headachy family, who had suffered from recurrent headache, was weaned from her complaint when she realized that the headache had been her weapon for getting constant change of environment and release from the dull routine of home. A patient who early develops megrim headache without obvious precipitating factors may later react to every disagreeable situation, to every unpleasant piece of news, with headache.

"In all such cases, therefore, it is necessary besides reviewing the ordinary simple causes of headaches, to pay some attention to the personality of the patient, to possible sources of emotional conflict, to any trying situation to which the patient has to react."

"Even in cases where there is some fundamental difficulty with the individual system or organ the physician may realize that the disability of the patient is disproportionate to the organic involvement; the patient seems to refuse to get well, although everything seems to favor recovery. It is well then for the physician to consider what forces tend towards recovery, and what forces postpone it; to scrutinize the situation and to see whether there may not be a subtle gain from the invalidism. It may then be found that the sickness is a powerful weapon or useful crutch, and before the patient will honestly seek health a change of attitude towards fundamental life problems must be brought about. The true nature of these problems can, as a rule, only be understood after a thorough review of the personality of the patient and a study of the patient's reactions to the more important tests of life."

PSYCHIATRY AT THE FRONT IN THE AMERICAN ARMIES. By Major Mortimer W. Raynor. *The State Hospital Quarterly*, 4:301–06, May 1919.

Major Raynor was divisional psychiatrist of the 79th Division from September, 1917, when it was organized at Camp Meade, until it was ordered home at the close of the year 1918. This address was based on his experiences for two months in the Argonne, the Troyon Sector and the Battle of the Meuse.

The duties of a divisional psychiatrist at the front are to keep up the fighting strength of the division and to eliminate promptly those who become unfit for duty; to examine and sort officers and men returning to advanced sanitary posts for exhaustion, concussion and neuroses; to treat the light cases, preserving as many as possible for duty; and to examine mentally prisoners and men suspected of having self-inflicted wounds.

The divisional psychiatrist during combat was stationed at the *triage*, or sorting station, which was as near the front as practicable. The sick and wounded were tagged either by the medical officer or an enlisted man of the regimental sanitary detachments, in a general way indicating that the man was wounded, gassed, sick or nervous. By using the term

"N.Y.D. (nervous)" for the latter group of cases, there was avoided any suggestion of "shell shock" or of their translating the term into a disorder recognized as incapacitating them. They were, therefore, open to the explanations of the medical officer that they were only tired or nervous.

The type of fighting determined to some extent the number of psychiatric cases. Open warfare with the men on the alert and moving forward produced fewer cases than when the fighting necessitated long periods of heavy bombardment with the men remaining in trenches or reserve positions. Artillery fire with the whistling of approaching shells, terrific detonations and terrible mutilations of comrades unnerved many men; whereas Major Raynor could not recall a single patient who referred to rifle or machine-gun fire as upsetting him.

Insufficient sleep, food and water, combined with days of constant fighting, were important factors in producing exhaustion. Fifty per cent of those evacuated as "gassed" were really fatigue and exhaustion cases. Of the medical cases reporting to the *triage* the most common diagnoses were bronchitis, influenza and diarrhea. In many cases the most important factor was fatigue. In the last group there were neuroses with tremors, speech and hearing disorders, ataxias, and stupors. The severe cases were evacuated to the advanced neuropsychiatric hospitals, while the milder ones were retained, treated and returned to duty.

True cases of concussion almost always asked to be returned promptly to their organization, which was allowed in the less severe cases. Aside from the milder cases of exhaustion sorted from the gassed and medical groups, the largest number of psychiatric cases were the exhausted with nervous symptoms. These were men who were worn out and unnerved by seeing comrades killed or injured or possibly by being knocked over themselves by a shell explosion. Major Raynor cited from his notes instances of this kind.

In treating these cases, field hospitals were operated under canvas, in old barracks or in partially destroyed buildings as near the *triage* as possible. The men were allowed to sleep as long as they wanted to and were given hot food and drinks. Medical cases were taken care of, and the patients were given a chance to relate what had happened to them. A brief neurological examination was made and they were told that they were tired and needed rest and food. The patients with tremors, speech disorders, etc., and those still tearful were isolated until the symptoms disappeared, as suggestion was a strong factor. Practically all these cases were returned to duty in from 24 to 96 hours.

Treatment within the division of the exhausted and milder nervous disorders, etc., discouraged the evacuation of large numbers of men. The fact that these conditions were not put on the same plane as wounds and also the fear of being considered "yellow" by their comrades influenced the men to "stick it out."

During the two months the 79th Division was at the front, the total losses were approximately 7,000, of which number 1,726 were diagnosed as gassed, 50 per cent of whom were cases of exhaustion. Approximately an equal number of medical cases were really exhaustions. There were 147 neuroses and true psychiatric cases, of whom 67 were evacuated and the rest treated and returned to duty. Four cases were evacuated a second time. There were 35 cases of "self-inflicted wounds," all of which were found to be accidental. A certain number of men were later found who had persistent nervous disorders. Many of these became apparent in the hospital after evacuation for some other cause.

In concluding, Major Raynor pays a tribute to the efficient manner in which Col. Thomas W. Salmon, M.C., Senior Consultant in Neuropsychiatry, organized, coordinated and directed this branch of the medical work with the army in France.

MALNUTRITION AND HEALTH EDUCATION. By David Mitchell. *The Pedagogical Seminary*, 26: 1–26, March 1919.

In February, 1918, the Bureau of Educational Experiments organized and held "nutrition classes" for about four months in Public School 64 in New York City. The children, 894 in number, were examined for height and weight, and where undernutrition was found, the cause was determined and an effort made to build the children up by establishing proper nourishment, rest periods and good habits, the removal, if necessary, of adenoids and tonsils, and the proper care of the teeth. Rest rooms and meals were provided in carrying out the experiment.

The children were divided into three groups: first, all who were seven per cent or more overweight; second, all those between seven per cent over- and seven per cent underweight; and third, all those seven per cent or more underweight. On the basis of the findings it may be concluded that 16.8 per cent of the entire school population are seven per cent or more under the weight which they should have for their height. In New York City this would mean that of the 1,000,000 school children 168,000 are undernourished. Among the children in the special classes studied, which comprised exceptionally bright children, 27.5 per cent were seven per cent or more underweight. In the "open air" classes, composed of children selected primarily because they were anæmic or because there was a history of tuberculosis in the family, only 28 per cent were seven per cent or more underweight.

The treatment given the 125 undernourished children in the nutrition classes, came under five general heads: (1) instruction in health habits; (2) removal of all physical defects that interfere with the processes of nutrition; (3) frequent periods of rest; (4) food given at frequent intervals rather than in larger quantities at infrequent intervals; (5) direct feeding—the provision of the actual food.

In making the arrangements for carrying out the experiment, the chief consideration was to determine the value of feeding compared with instruction in health habits. It was found that instruction in health habits was a very important factor. The children who received no instruction but were given a sufficiently large mid-day meal, gained only about one quarter of the amount expected of them during the time. The "open air" class gained only at about one half the rate expected, but their class was conducted under unfavorable conditions, the other children being present while the nutrition class was conducted. This was a constantly disturbing element. The result with the children in the special classes showed a total gain of 61.6 pounds for the 17 children. Their expected gain was 43.2 pounds for the period, giving a net gain of 18.4 pounds, almost 50 per cent more than the average expected gain.

Enlarged tonsils and adenoids apparently have a decided effect upon the nutrition of a child. An interesting table shows the per cent of gain of children before and after tonsil and adenoid operation. Other data are furnished with reference to the effect of carious teeth upon nutrition, but the numbers are too small to lead to any clear-cut conclusions. The figures suggest that the teeth may be in quite faulty condition without interfering with the process of digestion. Charts showing the records of individual children are also presented.

The report includes a mass of interesting data, and a table is presented, the use of which enables one to determine the average weight for any given height of a boy or a girl from two to sixteen years of age. This table is constructed on the basis of data furnished by Holt, Burk, and Boas.

The nutrition class works on the assumption that every child wants to be like other children. Various methods are used to promote the necessary competition. The problem must be met not alone by school feeding but also by an educational procedure. It is not sufficient to bring a child up to normal weight and leave him without habits which would enable him to continue in that condition. He must be educated in matters of personal health and hygiene, in the reasons for eliminating certain things, also the reasons for the observance of other things, such as proper amount of food, periods of rest and sleep, slow eating, etc.

The report presents the following conclusions:

1. Every child should be weighed and measured and those who are as much as seven per cent underweight for their height should be selected for nutrition classes.

2. Provision of food is not in itself adequate to solve the problem of malnutrition.

3. Habits such as rapid eating, using water as a flush, eating when excessively fatigued or irregularly, should be corrected.

4. Stimulants, such as tea and coffee, must be eliminated.

5. Physical defects, such as naso-pharyngeal obstructions, must be removed.

6. The amount of food should be carefully measured. A record of two consecutive days' consumption is a fairly reliable index for a week.

7. Rest and food should be given at not too long intervals. A mid-morning lunch and rest are needed by those children who are unable to store up a reserve of energy.

8. The nutrition class offers an opportunity for teaching many children hygiene and health habits. The competitive spirit is aroused. The chart shows actual gains or losses, and the children see the connection between these changes and the things that are spoken of as causes.

SURVEY OF PROVINCE OF MANITOBA, 1918. By the CANADIAN NATIONAL COMMITTEE FOR MENTAL HYGIENE.

In October, 1918, the Canadian National Committee for Mental Hygiene, at the request of the Public Welfare Commission of the Province of Manitoba, began a study of conditions in that province particularly with reference to hospitals for mental diseases and institutions caring for mental defectives. The investigation included a survey of the two hospitals for mental diseases, the Portage La Prairie Home for Incurables, the East Kildonan Home for Feebleminded Children, Stony Mountain Penitentiary, reformatories, gaols, institutions for dependent poor, institutions for normal children, primary schools, a visit to the Huetterite Colony at Bernard, examination of 50 consecutive cases appearing before Juvenile Court, examination of 50 consecutive cases appearing before Police Court, study of all legislation dealing with insane, feebleminded and epileptic, and study of medical education and provision made for psychiatry.

Facts brought forward by the survey were the number and location of the insane, feebleminded and epileptic in the province; the relationship of those outside suitable institutions to such problems as crime, juvenile delinquency, prostitution, illegitimacy, alcoholism, pauperism and unemployment; present methods of treatment; defects in present legislation dealing with them; proportion born outside Canada; efficacy of present methods in preventing mental disease and defect, crime, juvenile delinquency, prostitution, illegitimacy, alcoholism, pauperism and unemployment; and effect of the feebleminded upon primary school educational efficiency and school morals.

Among the recommendations presented by the Committee in concluding its report are the following:

1. That a commission responsible to the Province be developed and empowered to inspect, control and direct the activities of all institutions supported by government aid.

2. That the chronic insane be segregated in the hospital at Brandon.

3. That a farm colony be established to accommodate fifty male patients.
4. That the medical staff be of ample size and include a pathologist fully qualified in serology and bacteriology.
5. That every patient admitted be the subject of study and discussion at staff meetings, which should be held twice a week at least.
6. That the nursing staff be composed of qualified nurses of good education.
7. That a convalescent home be established near Winnipeg for complete restoration of patients before their discharge into the community.
8. That voluntary admissions be authorized.
9. That regular admissions be made upon the certificates of the properly qualified physicians after the superintendent of a hospital for mental diseases has made an examination of a preliminary form of history to be filled in by the physician in attendance.
10. That gaols as places of detention for dangerous insane be avoided.
11. That the federal authorities be asked to make a careful study of the problem of immigration and provide the proper remedies.
12. That two mental clinics for prevention and after-care be organized—an outdoor clinic attached to the Psychopathic Pavilion, and a clinic established in connection with the hospital for mental diseases at Brandon. The latter would act as an itinerant clinic.
13. That careful study of prisoners be made from the psychiatric and psychological points of view, to weed out the mental defectives and the mentally diseased.
14. That the feebleminded be segregated in suitable institutions of the farm colony type, with adequate provision for segregation according to sex, degree of mental defect, and reason for commitment.
15. That a special institution be provided for defective delinquents.
16. That all children attending the public schools receive a mental and physical examination at stated intervals.
17. That backward classes be used as observation centers and only such pupils retained as are found suitable for the specialized instruction and care afforded.

REPORT OF THE MAINE COMMISSION FOR THE FEEBLEMINDED AND OF THE SURVEY BY THE NATIONAL COMMITTEE FOR MENTAL HYGIENE, September 1, 1917—September 1, 1918.

In accordance with a resolution passed by the legislature of Maine in 1917, the Governor with the advice and consent of the Council, appointed a commission to make a "thorough and complete study of the feebleminded within the state and report with recommendations as to the future policy of the state." This commission was composed of Ex-Chief Justice William P. Whitehouse, Augusta, Chairman; Rev. David N. Beach, Bangor; and Mrs. Marion D. Eaton, of Portland. This commission invited The National Committee for Mental Hygiene to furnish an expert to serve as secretary to the commission and as director of the survey. Dr. Guy G. Fernald was selected, who carried on the investigation for a year and prepared the report.

The tentative plan of the survey as outlined is as follows:

1. "A study of the laws of the state, pertaining to the care of those suffering from mental disease.

2. "A study of the facilities in the State of Maine for the care of the feebleminded.
    a. Public institutions
    b. Private institutions
    c. Special classes in public schools, etc.

3. "The gathering of the data from which it would be possible to prepare a reliable estimate of the number of the feebleminded in the state by an examination of
    a. Inmates in institutions, state hospitals for the insane, prisons, reformatories and other state institutions
    b. County and municipal institutions caring for the poor, misdemeanants and dependents
    c. The institutions and societies caring for children
    d. Private societies engaged in work for the poor and unfortunate, associated charities, Florence Crittendon Homes, etc.
    e. The examination of children in schools of the state to establish the amount of serious retardation and to determine approximately, at least, the number of these children who are definitely febeleminded.

4. "Such other local problems as seem important and for which there is time.

5. "The analysis and correlation of the data gathered in the above studies and the preparation of a constructive program."

"Since trained field investigators were not available and the time of the Director for making intensive mentality examinations and collecting data could not be extended beyond one year and since, moreover, the survey was preliminary and educative in its nature and purposes, an economic expenditure of expert energy dictated the utilization of information in the possession of intelligent and volunteer local observers, i.e., the town officials and professionally trained citizens.

"In seeking a basis for an estimate of the numbers of the feebleminded recourse was had, therefore, to those who know the members of the class in their own locality. The township was selected as the unit and town officers were solicited by preference, though in very many larger towns and in all cities an informal conference was arranged at which a physician or teacher was usually present. In many towns, however, laymen's applications of our definition have furnished the estimates of numbers."

During the survey 162 cases were intensively studied and recorded. Returns were obtained from 164 cities, townships and plantations, and 121 institutions, including almshouses and jails. Estimates of the numbers of the feebleminded in these institutions were secured from local observers. Twelve rooms of public school children and four special groups were given congregate intelligence tests, and three degenerate communities were several times visited.

The intelligence tests used in the schoolrooms were those of Lyman F. Wells, Psychologist at McLean Hospital, Waverley, Massachusetts. "The tests used in our individual personality examinations were: (1) psychiatric tests adapted to the determination of the absence or presence and the varieties of mental diseases, (2) searches in the field of intelligence by means of the standard 'Terman Tests,' enabling a numerical valuation in terms of intelligence quotient and intelligence age level, supplemented or substituted in the case of adults by unstandardized tests which have been found of value in classifying mentalities of adults, and (3) searches in the field of character by the inductive method, since tests in this field, like those in the field of mental diseases, are not yet susceptible of numerical scoring."

From the studies made there were estimated to be 1,659 persons obviously feebleminded, their distribution being shown by the following table:

	Supported or helped by the town or state	*At large in the community*	*Total*	*Population represented*	*Number per thousand*
In urban districts of 2,500 or more	61	262	323	262,652	1.25
In rural towns of less than 2,500	112	145	257	167,130	1.54
Total	173	407	580	429,782	1.35
Estimated population of Maine				783,350	
Number per thousand, 1.35 applied to state's population			1,058	353,568	
In 121 special schools, hospitals, city and county almshouses, jails, etc.	601		601		
Grand total	774		1,659		2.12

The feebleminded in the institutions of Maine are shown by the following table:

Name of institution	*Population*	*Number of feebleminded*
Augusta State Hospital	1,018	80
Bangor State Hospital[*]	691	78
Eastern Maine Orphans' Home	...	..
Maine State Prison	200	2
Maine School for the Blind	31	1
Maine School for the Deaf	102	10
Maine School for the Feebleminded	262	262
Maine State School for Boys	135	15
Maine State School for Girls[†]	185	23
Woman's Reformatory	51	15
Fifteen city and county almshouses[‡]	205	33
Eighty other almshouses of known population show a prevalence computed on the ratio of the 15	350	56
Sixteen county jails	239	8
Total	3,469	583

Although 1,659, or 2.12 per thousand of the population, were obviously low-grade feebleminded, the report emphasizes the fact that this gives no indication of the number of high-grade feebleminded, the class which on the whole are the greater sociologic and economic menace. The cases of mental defect, deviation and other aberration found, did not differ essentially in kind or number from those of similar communities elsewhere. Maine was found unique in one regard as to population, however—the increase since 1850 has been much slower than that of the United States as a whole.

The great majority of Maine's feebleminded are scattered fairly evenly throughout the state in both cities and rural districts. They quarrel freely among themselves, show no inherent cohesiveness and, especially certain mill operatives, part-time laborers and domestics, drift from place to place.

Twelve teachers in various parts of the state informally reported backward or peculiar children, but none of them could be reached for examination. Some of these children are undoubtedly feebleminded and there are many who need training in a special class. But in one special class in a factory village the only difficulty was the foreign tongue and the language of the home. The State School Report for 1916 shows 165 boys and 157 girls in special classes in fourteen counties

[*] Excluding 19 constitutional inferiors.

[†] Only 65 doubtful cases were examined. Case summaries or abstracts of some of these are given.

[‡] For the populations of almshouses not visited we are indebted to the *Fourth Annual Report of the State Board of Charities and Corrections*.

and in academies. The average daily school attendance for the state was 102,877.

There has been a failure in most of the towns to provide for school medical inspection. Some form of state organization for this purpose will undoubtedly be organized. The Commission suggests, before the corps of medical inspectors is organized, that public school medical examiners be affiliated with or directed by a state psychiatric staff so that guardians of doubtful cases would have the advantage of the best psychiatric advice early in the development of the child.

The importance of controlling the activities of the feebleminded is apparent. The state and city commissions appointed to investigate prostitution and the vices and diseases that go with it, report that from 50 to 80 per cent of prostitutes are feebleminded (including the higher grades of feeblemindedness). The unsupervised feebleminded girl is a grave menace, either potential or actual.

The propaganda in Maine for better mental hygiene in the field of feeblemindedness is a philanthropic sociologic movement for social uplift. Its method of realization is to suppress parenthood among the unfit and to supervise the activities of the feebleminded. The estimate is that 80 per cent of feeblemindedness is inherited. If attention is focused on this generation alone the prospects of diminishing the burden is small, but taking well considered steps now, before the end of another generation there should be a marked decrease in the number of feebleminded.

The Commission feels that if a judicial investigation by experts of the thinking capacity and responsibility of all criminal offenders were instituted and all mental defect were examined and registered, it would act as a deterrent to lawlessness and be very valuable, as offenders could be dealt with on the basis of their mentality as well as culpability.

The great need for the organization of psychiatric skill under state control has been indicated by the large number of applications received by the Director's office for diagnosis of mental defect and deviation. They came from physicians, officials, institution heads, charities and welfare societies and from parents and guardians. Most of the inquiries related to the disposal of cases. The need in Maine of a body of psychiatrists to determine borderline cases, to recommend treatment and to carry out sociologic projects is very apparent. The organization of a state board or commission would rouse a spirit of progress along these lines among young medical men and students.

Recourse to amendment of laws should not be considered until the public is receptive and ready to support the measures proposed. At present a small force of field workers should supervise the extra-institutional feebleminded, possibly one in each city and one in each rural district comparable in size to a county. These workers should be selected, trained and directed by a state staff of psychiatrists. The state psychiatric staff or commission would be responsible for registering, diagnosticating and distributing cases and for making case records and studies from them.

The report gives comprehensive graphs of three degenerate communities, showing their consanguineous marriages and mental classifications. Each community graphed has been represented by a disproportionately large number of inmates of juvenile and penal institutions as well as jails and almshouses. In many instances child welfare agencies have found it best to separate children from their parents. One of the largest degenerate communities, that on Malagre Island, was dispersed by the state's taking over the island and annexing it to an adjoining town. The squatters were told to disperse. Three consignments of feebleminded children were sent to the State School for Feebleminded from this one island.

In addition to an account of the findings and recommendations for each institution investigated, statistical tables are presented with reference to four groups of abnormal persons intensively studied; data showing the distribution of the feebleminded in the community and in institutions; photographs of feebleminded in the community, their dwellings and surroundings; graphic presentations of degenerate communities; a number of case and family histories; and an appendix containing definitions of the types of mental defectives, an outline of mentality study and six bulletins issued by the Commission. The more immediate needs of the state and some of the machinery for supplying them are briefly stated in the following recommendations of the Commission:

1. "Education of the public on the problems of feeblemindedness and the means of solution, i.e., Maine citizens should know the numbers of the class and especially of the inimical, high-grade feebleminded, many of whom are potential offenders. They should know the cost of supporting these in idleness and vice on the one hand, and of training them in youth to economic usefulness on the other. Maine people should know the importance of detecting those of degenerate stocks whose progeny is most sure to be dependent, in order to plan for the elimination of these in the future. Maine people should be convinced that feeblemindedness in the community is a burden which may be humanely diminished.

2. "The extension of the mental clinic idea, now happily inaugurated in Maine, to the establishment of clinics in the other large cities at which guardians, judges and court officers, institution heads, physicians, teachers, and others may ascertain the mental status of those whose behavior suggests investigation.

3. "Provision for the enactment of a suitable commitment law, placing the control of all feebleminded in the hands of the state's experts,

so that those of both the intra- and the extra-institutional types may be appropriately treated.

4. "Extension of the State School for the Feebleminded and the Woman's Reformatory to twice or three times their present capacity in the attempt to relieve the communities of the intra-institutional feebleminded and inimical female offenders.

5. "Provision for the freest use by the courts of the findings of the state's alienists.

6. "Provision for more intensive teaching of psychiatry in the state's medical schools and for the teaching in the normal schools of the available means of securing a diagnosis of suspected cases of mental defect in children.

7. "Extension of medical inspection in the public schools to the early discovery of cases of mental defect, deviation and disease.

8. "Examination and classification of all inmates of penal and reformatory institutions.

9. "Provision for the inauguration of a continuing census of the state's feebleminded.

10. "A continuing voluntary association of competent citizens to organize research, to educate public opinion and to formulate measures for legislative enactment.

11. "State recognition of the psychiatrical resources of the state and the organization thereof for the examination, registration and supervision of the state's feebleminded."

BOOK REVIEWS

MORBID FEARS AND COMPULSIONS; THEIR PSYCHOLOGY AND PSYCHOANALYTIC TREATMENT. By H. W. Frink, M. D. New York: Moffat, Yard and Company, 1918. 568 p.

In this book Drs. Frink not only discusses the symptomatology and mechanisms of morbid fears, but he gives a long and careful review of the psychological mechanisms which are involved in the psychoneuroses. The author has been very much influenced by the writings of Freud, and accepts in detail the teachings of the latter, even when they are most hazardous and hypothetical. At the same time one finds the first suggestion of a *rapprochement* between two extreme modes of statement, an attempt at the formulation of the underlying truths of Freud's doctrines in terms which are in harmony with the rest of our biological and psychopathological knowledge. The author frequently puts side by side the conventional jargon (*sit venia verbo*) of the Freudian school, and a more familiar and intelligible formulation of the same facts. In many branches of science one must introduce a new terminology to do justice to new facts or to new conception of familiar facts, but there are certain general canons which should determine the nomenclature, and the acceptance of much excellent work has been retarded by its artificial phraseology. The author shows a certain sensitiveness to this situation, and the peculiar phraseology of the Freudian school is to a certain measure neutralized by the alternative formulation in ordinary English without too many terms derived from mythology. That the author has not shaken himself free from the Freudian tradition is seen in his description of the sensitiveness of an overconscientious clerk as due to "a certain measure of the narcissistic homosexual libido" failing of satisfaction, and regressing in the direction of earlier points of attachment.

The book has an introduction by Dr. James J. Putnam. The first five chapters (pages 1–270) are an exposition of Freudian psychopathology. The following five chapters are devoted to the topic which gives the title to the book. The last chapter gives the author's views of the factors which are involved in the cure or lack of cure by means of the psychoanalytic treatment.

The book is very long because the author takes great pains to make his thought clear; he has used numerous examples to illustrate his points; he has not hesitated to repeat when necessary. Such a detailed exposition will be very welcome, for condensation involves much labor to the reader and is, after all, no true economy. Chapter seven (pages 308–430) gives a case in great detail. The elaborate interpretations in this case are, as always in similar cases, open to some criticism, but the general presentation is clear and one can follow easily the mechanisms which the author emphasizes.

The book is a welcome contribution to psychoanalytic literature, and is all the more so because it is free from any attempt to dazzle by means of daring new hypotheses without foundation. It should be a great help in stripping the excellent work of the Freudian school of some of its exotic coverings, thus making it more suitable for assimilation with the findings of other schools of psychology and psychopathology.

C. MACFIE CAMPBELL.

CLINICAL STUDIES IN FEEBLEMINDEDNESS. By Edgar A. Doll. Boston: Richard G. Badger, 1917. 232 p.

The outstanding merit of this little book lies in the detailed reports of case histories in feeblemindedness. These case histories, of which there are six, concern a potentially feebleminded individual, a potentially normal, a neurotic or psychopathic deaf-mute not feebleminded, a psychopath with slight intellectual retardation not amounting to feeblemindedness, and a high-grade borderline immigrant, offering very convincing clinical proof of the diagnostic value of the Binet-Simon measuring scale of intelligence which, by the way, no one who understands feeblemindedness is inclined to question. The psychometricians, however, still seem to feel the need of mustering evidence in proof of this contention, especially when it serves to delimit the place of the study of feeblemindedness within the field of medicine.

Doll, for instance, finds it necessary to state, "We positively disclaim any intimation that a physician or medical specialist is not qualified to diagnose feeblemindedness. Except for a small minority of cases, our whole contention is that such a person cannot do so by the medical data directly."

Inasmuch as the earliest studies in this field were carried on by medical practitioners, and that essentially and from the practical point of view, feeblemindedness must be looked upon as a type of pathological human behavior (a problem in medicine), we doubt the necessity of such concessions as Doll makes.

A greater willingness on the part of the psychometricians to see the neurologist's and psychiatrist's points of view might open their eyes to the fact that no well equipped and well conducted hospital for the treatment of disordered human conduct ignores the value of psychometry as a diagnostic instrument.

Has not the time arrived when our psychologists might devote more time and effort to a clarification of the subject of mental deficiency, in which we are all interested, instead of wasting so much time in telling the physician what his sphere of professional interest should be?

The glossary of terms and bibliography ought to be of value to those interested in the subject of feeblemindedness.

BERNARD GLUECK.

THE PSYCHONEUROSES OF THE WAR. By G. Roussy and J. Lhermitte. London: University of London Press, 1918. 177 p.

This short book, translated by Wilfred B. Christopherson, is first of all useful to and intended for those actually engaged in the handling and care of soldiers suffering from nervous and mental disorders. It aims to be entirely faithful to observed fact and in a large measure it is so. The authors have their own doctrine which in general follows that of Babinski. But they are not controversial. They cling closely to actual observation, though not to the detriment of the point of view they hold.

The book deals primarily with the psychoneuroses of war. Indirectly it treats also of conditions with which the psychoneuroses may be confused or contrasted. The result is a well defined, clearly constructed monograph free, on one hand from too great didactic detail and, on the other, richly suggestive without being vague or doctrinaire. The text deals painstakingly with motor disorders, paralyses, contractures, disorders of gait, tremors, tics and with psychical disturbances of sensation. The portion of the book dealing with the latter is especially well done. The visceral disorders are treated briefly and as a transition to the discussion of psychical disorders. The authors deal also briefly with attacks of terror and motor agitation. The discussion follows the textbook form of description and diagnosis, with liberal attention to differential features such as the man on the run finds useful. Excellent summaries conclude each section. There are also numerous photographs of psychomotor disorders with very adequate legends.

The psychical disorders arising in relation to the war receive admirable treatment. It is not the least the merit of this discussion that the authors make of it a background for the concluding descriptive chapter which deals with the matter of concussion. They clearly tease out the organic etiological factors and effects from those of psychogenic nature with open fair-mindedness. The etiological considerations are summarized in a final chapter in what might be regarded as too brief a manner. Especial emphasis is laid on the prevalence of psychopathic constitution and on alcohol. The rôle of emotion is very hastily dealt with in this connection. The chapter on treatment adds essentially nothing to what is already well known to any one who has followed with even casual interest the current literature of the war neuroses. The bpok contains at the end a few pages on the psychoneuroses and military decisions.

The book must be set down as excellent and adequate for the purpose for which it is written. It is confessedly a summary. Reference to specific cases is lacking. With time it is to be hoped that the authors may publish detailed studies of cases to which those who are interested in more detailed study of the psychoneuroses may refer.

G. S. AMSDEN.

FUNDAMENTALS OF CHILD STUDY; A DISCUSSION OF INSTINCTS AND OTHER FACTORS IN HUMAN DEVELOPMENT WITH PRACTICAL APPLICATIONS. By Edwin A. Kirkpatrick. New York: The Macmillan Company, 1917. 380 p.

This is a department-store type of book. It brings together in one volume, in the most convenient form possible, a vast amount of useful information regarding child development. There is great need for such books and the demand for *Fundamentals of Child Study* has brought it to a third edition.

It has not escaped the fault of the general-purpose type of book, for it gives the reader a greater sense of confidence in the conclusiveness of the information presented than the facts of science justify. Since the book will undoubtedly become the very gospel of educational practice for many teachers, it is unfortunate Kirkpatrick did not give the book that suggestion of something-more-to-know which marks the most skilful and useful book of this kind. Teachers and parents surely need open minds as much as they need systematized satisfaction. If the references suggested by the author are read this sense of security will, of course, dissolve rapidly but many will be satisfied with the text and will leave the book ill prepared to appreciate how alien to the facts is any suggestion of finality with reference to such a problem as that of human instincts.

Psychologically the book is orthodox and the reader is not given even a glimpse of the claims staked by the Freudians which they consider so rich in the ore of child understanding. All Freudians, and others beside, will regret that a book going into the hands of the average teacher and parent states that fear in the milder forms may be made a useful motive in child development (page 134).

The book has a full bibliography but it is lacking in very recent citations, especially those in the field of abnormal psychology. The book will prove of value to few readers of MENTAL HYGIENE.

ERNEST R. GROVES.

THE PSYCHOLOGY OF MARRIAGE. By Walter M. Gallichan. New York: F. A. Stokes, 1918. 300 p.

This belongs to that ever multiplying brand of book which we are compelled to label "not genuine psychology, only psychology plated." Literature of a quasi-scientific character has the habit of wandering over the surface of the department of thought whose title it appropriates, culling the names of a few writers for incidental reference and then launching forth into a miscellany of information on the plan of a Baedecker. This volume is no exception. Its sincere purpose is that of guidebook to the understanding of the problems of premarital and conjugal life. It is apparently addressed to English readers, who still need elementary counsels upon sexual physiology, hygiene and ethics. Its sentimental presentation of these subjects can hardly appeal to the alert American student, married or unmarried, by whom experimental findings in the field of sex psychology are beginning to be known.

Such statements as the following stamp the book instantly with its inherent weakness: "If a suitor's handgrasp or kiss does not whisper of heaven to a woman's heart, he is not the lover of her natural desire." "It should be known that the desire of the sexes for one another is not an automatic physiological impulse, but chiefly and normally a profound wish born in the brain and associated with the tenderest and most beneficent emotions in all instances of truly fervent love. The seat of this physical and emotional feeling is in the cortex of the brain and its manifestation is often against the will of the individual."

Notwithstanding copious quotations from a wide range of writers, the author's bibliography on psychology of sex appears to begin and end with Freud, Hall, and Ellis. Nowhere is there a reference to sound experimental works on differential psychology or even a grasp of fundamental principles. He claims that the girl is by original tendency more modest and more subject to revulsions than her brother. Scientific psychologists have not determined such a sex difference. He talks of the three stages of marriage—"the capture, purchase and contract." The hypothesis that capture was instinctive at the time and that the resistance of woman in love is still instinctive is psychologically untenable because it is based on the assumption that woman is by original nature opposed to the sexual relation. Again, the tendency to dominate is present in every normal individual and we find no warrant for the declaration here that woman is primarily desirous for man to dominate her physically.

Mr. Gallichan's social psychology is inconsistent with current theories of the original nature of man and oblivious to the present status of measurement of sex differences. Furthermore, he shows lack of acquaintance with the trend of contemporary biological science as well. One example of this is his position on the so-called transmission of "racial poisons" through the germ plasm. Indeed his entire treatment of the venereal problem is naïve.

His exposition of the eugenic program is sane and clear sighted. There is a wealth of advice worthy of unhesitating approbation and hence it may seem a bit ungracious to point out the foregoing flaws. They will not be detected by the lay reader but the student cannot seriously regard it as an authoritative contribution. MIRIAM C. GOULD.

MENTAL CONFLICTS AND MISCONDUCT. By William Healy, M.D. Boston: Little, Brown & Company, 1917. 330 p.

The thesis of the book is stated in the first lines of the introduction: "A remarkable dynamic quality characterizing certain hidden mental reactions to experiences is responsible in some individuals for the production of misconduct, or, indeed, whole careers of delinquency." The author has found that a study of the physical development and family history and inquiry into environmental conditions are insufficient in certain cases of abnormal behavior. In one thousand cases of youthful recidivists, there were seventy-three cases where mental conflict was the main cause of the delinquencies.

The first four chapters of the book are given over to a description of analysis, which is termed "mental analysis" in preference to psychoanalysis. In the presentation one finds the familiar terms, conflict, repression, conversion, substitution, etc., but in the real material of the book which follows there is little application made of the technical terms, and the author states that in his investigation he found little necessity for using dream analysis or invoking symbolism. The forty cases which form the body of the book are extremely interesting and convincing because they are presented in a simple direct manner. The majority of individuals studied were children and in the cases presented the vital experiences are given in the child's own words, which need no elaborate interpretation. The material is divided under various chapter headings: *Conflicts Accompanied by Obsessive Imagery, Conflicts Causing Impelling Ideas, Criminal Careers Developed from Conflicts*, etc., but in the main the problems which led to the investigation were, stealing in a great number of instances, running away from home, lying, disobedience, irritability, bad temper, "malicious mischief," etc. It was most frequently the case that the child had had some unfortunate sex experience or had acquired from the person responsible for the change in his reaction and habits sex knowledge that stimulated ruminations and cravings which he secretly combated. Very often the children in relating their experiences speak of the headache which they suffer when they think of the tabooed word or recall the suggestive pictures. One is tempted to speculate why it is that a neurosis does not develop. It may be because children do not tend to lapse readily into invalidism, and have greater freedom than adults in expressing tension and unrest as misbehavior in varying forms. In the final chapter the author raises the question whether mental conflict represents a reaction that implies a peculiar constitution, and inquires to what extent misdoers through mental conflict are neurotic. He also discusses the problem of heredity, age of onset of the conflict, length of time a conflict may lie dormant, special mental traits, general abilities, the results of special tests, etc. Healy is unable to satisfy his own inquiry about the complete normality or abnormality in reaction type of those who develop mental conflicts. The desire for finality and nicety of distinction tends to create artificial standards and one is relieved to find that the author emphasizes the peculiar settings in which the experiences occur, the lack of opportunity for ventilation of the conflicts and the absence of sympathetic guidance.

A. Scott.

PSYCHOLOGICAL TESTS; REVISED AND CLASSIFIED BIBLIOGRAPHY. By David Mitchell and Georgie J. Ruger. New York: Bureau of Educational Experiments, 1918. 116 p. (Bulletin 9)

The compilation of the above bibliography of mental tests, and the present revision, will be of special value to all who are interested in the growth and extension of the fields of mental testing. It is perhaps better suited to the uses of the expert than as a guide for those who are able to spend considerable time in this special field. Some method of indicating treatises and final summaries, perhaps under a separate section, would enable the non-expert to keep up his acquaintance with the principal lines of progress.

The total numbered items are 1428. Many articles are repeated in different sections, so that the actual total is nowhere indicated. It is presumed that when the bibliography of "articles of earlier date" is completed this method will be changed so that the quantitative growth can be noted.

Four pages are devoted to an enumeration of tests by name, together with names of authors reporting on the tests. It is somewhat difficult to determine why the authors decided names of certain tests should appear and others be omitted.

This and other previous efforts to list tests by name suggest interesting possibilities. There is no apparent reason why names may not continue to multiply. Perhaps it is not too early to suggest that the selection of some mechanical system of classification would be greeted with enthusiasm by the compilers of bibliographies. It is conceivably the just procedure, since no single author would care to accept the responsibility of offering an "intrinsic" classification.

CLARENCE S. YOAKUM.

SCHOOL ORGANIZATION AND THE INDIVIDUAL CHILD; GRADING AND SPECIAL SCHOOLS. By W. H. Holmes. Worcester: The Davis Press, 1912. 142 p.

The school, according to Holmes, should simplify its course of study in the fundamentals to insure its completion by every normal child. It can then allow the bright pupil to do intensive work. If individual instruction supplements class work, the advantages of the old ungraded school may be regained.

Special schools for subnormal children provide a means of detecting the feebleminded in need of institutional care. Quoting such authorities as Goddard, Tredgold and Havelock Ellis, the author stresses the dangers created by the feebleminded at large in the community. He records the Binet-Simon mental tests with comments and criticisms by Terman, Kuhlmann and others. The Terman Revision of the Binet-Simon tests had not yet appeared.

After-care of the special-school pupil receives merited prominence at the hands of Holmes.

Although there is little original material in the book, it is valuable as a popular presentation of the question of segregation *versus* sterilization of the feebleminded adolescent.

ERNEST R. GROVES.

HEREDITY AND ENVIRONMENT IN THE DEVELOPMENT OF MAN. By Edwin Grant Conklin. Princeton: Princeton University Press, 1918. 550 p.

Professor Conklin has presented in brief form the essential general facts concerning physical and mental development of organisms and has traced the cellular basis of development and of heredity. He discusses rather fully the phenomena of inheritance and describes the principal achievements in the experimental studies of that subject during the past eighteen years. He points out briefly general facts concerning modification of development by environment and in two final chapters discusses the improvements of cultivated plants, domesticated animals and man, and also the relation of genetics to ethics.

For readers of MENTAL HYGIENE Conklin's position on eugenics is especially to the point. As a biologist Conklin has no doubt at all about the universal importance of heredity in relation to society and in determining the qualities of individual men. When it comes to the matter of determinism and responsibility Conklin is inclined to take a middle ground. The middle of the road is generally regarded as the safest course but in the present instance one cannot help feeling that Conklin's conclusions on this subject are influenced by non-biological considerations. He says (p. 482): "Freedom is the more or less limited capacity of the highest organisms to inhibit instinctive and non-rational acts by intellectual and rational stimuli and to regulate behavior in the light of past experience." Freedom, thus defined, is as Conklin suggests of a limited sort. One wonders if freedom is really not more limited than even this cautious sentence implies. Inhibition of instincts is itself an instinct, as we see indeed in dogs, as for instance in the retriever which brings back the delicate bird without biting it. Inhibitions can indeed be cultivated when the germs of them are present, but if the germs are not present then the individual can not inhibit. The capacity for inhibitions may be quite as automatic and as instinctive as the instinct itself.

Of the literary and mechanical characteristics of the book one can speak only in the highest praise. Professor Conklin is an extraordinarily clear and attractive writer and the book is well printed and convenient to handle. It is an excellent introduction to the subject of human heredity.

CHARLES B. DAVENPORT.

SYPHILIS AND PUBLIC HEALTH. By Lieut.-Col. Edward B. Vedder, M. C., U. S. A. Philadelphia: Lea and Febiger, 1918. 315 p.

Colonel Vedder's studies in the epidemiology of syphilis, well known to syphilographers in this country, have culminated logically in the notable contribution to technical syphilology and the science of public health represented by the book whose title appears above. The work makes an immediate impression as a scholarly and singularly complete presentation of a subject now crossing a new threshold of world interest and world enlightenment.

The book includes an introduction setting forth the importance of syphilis as a public health problem and a factor in mortality; a remarkable chapter on the prevalence of syphilis; chapters on each of the following subjects: sources of infection and methods of transmission, personal prophylaxis, public health measures; and an appendix detailing a Wassermann technic, citations from special laws and systems of control including the West Australian, and an index of authors and subjects.

The first chapter, a monograph in itself embracing 108 pages and citing in its bibliography 143 titles, is a monumental contribution of permanent value to the literature. Much more than this, it is an arsenal of effective weapons for those who are engaged in bringing home to an as yet unawakened public intelligence, the tremendous significance of syphilis for the future of the race and its overwhelming importance among the public health problems of today. It enables the individual syphilographer, the public health officer, the lecturer, to replace vague and untrustworthy personal estimates and experience with a mass of detailed information whose exactness is a matter of surprise even to the more than casual student of the problem. This feature of the work alone makes it an indispensable reference.

The chapter dealing with the sources of infection and the transmission of the disease is also replete with valuable statistical material. The problems are succinctly stated and the experimental evidence underlying modern conceptions is well, though perhaps a little too briefly, set forth. It is inevitable that in a work destined for the general medical and perhaps lay public the discussion of such problems as maternal infection and the paternal transmission of syphilis should be curtailed, although the syphilographer cannot but regret that Colonel Vedder did not feel it advisable to bring his scholarly mode of attack to bear upon this much mooted subject.

Personal prophylaxis is discussed with the same completeness that characterizes the whole work. The *résumé* of the literature on the effect of circumcision as a preventative and the history of mechanical and chemical prophylaxis is replete with interesting detail. The standard set for the marriage of syphilitics is commendably conservative though not extreme. A momentary confusion is introduced by the earlier mention of the spinal fluid examination and its apparent omission in the final modification of the Finger standard.

In his discussion of the sociological background of syphilis in the problem of sexual promiscuity and prostitution, Colonel Vedder indulges in a frank but tempered and well balanced pessimism. His direct appeal to efficient treatment as the main hope of prophylactic endeavor is well timed, and places a satisfying emphasis upon the rudimentary character of existing facilities and upon the reduction of the cost of treatment by abolition of private monopoly of arsphenamine. The appendix supplies a variety of technical details of value. While perhaps not strictly within the province of a work of this type, one cannot but wish that a minimum treatment standard had been given, since such a *résumé* would be of much use in a book certain to have a wide professional reading and an authoritative place in the literature. One cannot escape, too, the wish that Colonel Vedder had reviewed the relation of syphilis to industrial compensation and to health examination and insurance with the same completeness with which he has dealt with other aspects of the subject. While knowledge of these issues is still in its infancy, anything which he had felt willing to contribute would have had an eager hearing.

Critical comment on Colonel Vedder's book can deal only with minor details. The work is in every particular a remarkable one, certain to be widely read, and in the best sense, expressive of the erudition and exceptional experience of an authority.

JOHN H. STOKES.

THE PSYCHOLOGY OF BEHAVIOR. By Elizabeth Severn. New York: Dodd, Mead & Company, 1917. 349 p.

This book contains considerable everyday psychology, but its title should be the metaphysics of behavior rather than the psychology of behavior. It ignores the scientific studies of behavior in animals and men and the author herself distinctly states, "The viewpoint is frankly metaphysical rather than biological, and idealistic and suggestive rather than materialistic and positive." She adds, however, "Yet sight has not been lost of the need of exactitude where it is so easy to be vague, and emphasis has been placed upon the *governing principles* of human conduct rather than upon its particular phases."

The author reports extended experience in the practice of psychotherapy, and the book is largely based on such experience. It presents a fairly good outline of important facts in regard to feeling and emotion, and contains many suggestive paragraphs, but the exactitude claimed by the author is liable to be suspected by the reader, since the fundamental methods of science, upon which all exactitude must rest,—first-hand observation, experimentation and verification—are given up at the outset, and metaphysics invoked. The author's observation, however, is better than her point of view, and the common-sense observations and concrete phenomena reported are helpful.

The value of this book lies in the clear statement of some of the more common everyday facts of psychology and certain practical suggestions in mental hygiene, together with a good discussion of certain simple psychological and hygienic principles from the point of view of psychoanalysis. But the reader should not accept too literally some of the statements in regard to the mental processes. The writer says, for example, "We can perform no act that we have not previously been able to visualize" (p. 125). This ignores the imaginal differences as seen in those whose dominant imagery is motor, auditory, or vocal motor. Again, "broadly speaking, emotions may be divided and usually are into the two general groups of pleasure and pain." While pleasure is to be reckoned among the feelings, its opposite is displeasure rather than pain; and pain is, as modern investigation has shown, a sensation. It is unfortunate that a writer on psychology should not refer to the rich literature of comparative and human psychology; and to write on human behavior without regard to the investigations of Stanley Hall, Thorndike, Watson, Yerkes, and the other scientific workers in this field, is to give inevitably a one-sided, imperfect, and erroneous account.

Since this book is intended for the general reader, it might be said that as a contribution to psychology it is inaccurate and as a handbook on human behavior it is inadequate; but if the reader should label it *aspects of behavior from the point of view of a worker in psychotherapy*, then it would prove helpful, and contribute many practical suggestions presented in a pleasing and interesting style.

WILLIAM H. BURNHAM.

MEDICAL DISEASES OF THE WAR. 2d ed. By Arthur F. Hurst, M.D. (Oxon.), F. R. C. P., Temporary Major, R. A. M. C. London: Edward Arnold, 1918. 319 p.

The book is a revision of a work by the same author published in 1916. The chapter on *War Neuroses* has been expanded into eleven in the present edition. It is precisely these chapters dealing largely with hysteria that are neurologically of the greatest interest.

The contents of these eleven chapters are:

1. Predisposing Causes.
2. Exhaustion Resulting in Neurasthenia and Soldier's Heart.
3. Neuroses Resulting from Emotions.
    a. Stupor and Amnesia.
    b. Psychasthenia.
    c. Hysteria.
    d. Hyperadrenalism and Hyperthyroidism.
    e. Exaggerated Defensive Reflexes.

4. Shell Shock.
   a. Pure Concussion.
   b. Spinal Concussion.
   c. Hysterical Symptoms Grafted on to Organic Basis of Concussion.
5. Conditions Predisposing to the Development of Special Symptoms.
   a. Epilepsy.
   b. Mental Disorders.
   c. Tabes, General Paralysis and Cerebral Syphilis.
   d. Disease or Injury of a Limb.
   e. Past Emotional Disturbances. Psycho-analysis.
6. Motor Disorders.
   a. Hysterical Paralysis, Attitudes and Gaits.
   b. Tremor.
   c. Hysterical Contracture.
   d. Reflex Paralysis and Contracture.
   e. Hysterical Fits.
7. Disorders of Speech.
8. Disorders of Hearing.
9. Disorders of Vision.
10. Hysterical Pain.
11. The War and Organic Nervous Disease.

The writer agrees with Babinski's definition that hysterical symptoms result from suggestion on the part of the patient himself or on the part of somebody else, and that they are curable by persuasion and suggestion acting alone. He states: "There is no such thing as hysteria apart from hysterical symptoms. It might be supposed that the underlying mental condition which makes an individual liable to develop hysterical symptoms is hysteria, but there is no mental condition of this kind constantly present, as nobody is free from liability to develop hysterical symptoms if the suggestion is sufficiently strong."

The following are interesting extracts from the different chapters. "It is very rare for hysterical symptoms to develop actually in the trenches—. . . . In the dazed condition which results from prolonged mental strain the man is abnormally suggestible; his critical faculties are lost and his initiative is diminished. As he gradually comes to himself he tends to exaggerate and perpetuate the difficulties he experienced in the performance of the various functions of his body. The absence of movement due to absence of initiative leads to the suggestion of paralysis; the silence due to absence of any stimulus to speak in his confused mental condition suggests mutism, and the inattention, which prevents his hearing what is said to him, suggests deafness."

"It is essential for success in treatment that the medical officer should feel convinced that the patient's symptoms are not organic or are at most only in part organic. . . . Whatever treatment is employed, the encouragement produced by the presence of cured patients to those about to be treated is mostly helpful. . . . An atmosphere of cure in which the medical officer, the sisters and the recovered patients in the wards all play their part is of the greatest value for newcomers, however long they may have been ill before admission. . . . The patient is also made to understand that there is nothing unusual about his case. The extreme interest and sympathy with which he is surrounded account for the frequent persistence of hysterical symptoms for many months spent in some luxurious hospital. . . . Simple persuasion followed when necessary by re-education is all that is required to cure most hysterical symptoms. . . . Electricity is useless unless employed solely as a means of suggestion. . . . Electricity is particularly harmful when any tremor is present."

"Hypnotism is useful in the treatment of psychasthenia but it is generally not the most satisfactory means of treating hysterical symptoms."

"The term 'shell shock' should be reserved for the condition which follows exposure to the forces generated by the explosion of powerful shells in the absence of any visible injury to the head or spine."

"Hysterical tremor is very common and is due to the perpetuation by auto-suggestion of the tremor caused by fear."

"Hysterical fits are much more common in soldiers than might have been expected from their rarity among men in civil life. The idea of convulsions may be already present in a man's mind if he has previously suffered from true epilepsy, or if he has been the witness of convulsions in some near relation: horror or fright may then suggest an attack. The diagnosis of hysterical from true epileptic fits has generally to be made from the patient's own account of his attacks. A true history of involuntary micturition or of injury to the tongue caused by biting are the only points suggesting true epilepsy. A man rarely if ever has an hysterical fit when he is by himself; if his companions say that he has struggled with them, or clutched at objects near him, the fits are certainly hysterical. . . . The only signs which can be regarded as conclusive evidence against hysteria are definite cyanosis, complete loss of conjunctival and corneal reflexes, loss of the pupillary reaction to light and most conclusive of all an extensor plantar reflex tested as soon as the convulsions have ceased and before consciousness has returned. In cases of doubt I have tried to induce an attack by suggestion under hypnosis. In hysteria a fit is generally produced at once. . . . I always combine this method of diagnosis with treatment by telling the patient before, during and after the fit that this one will be the last he will ever have. The treatment has proved most successful."

"The majority of cases of hysterical aphonia which I have seen in soldiers followed laryngitis. . . . Hysterical aphonia generally recovers after the application of a sound, or in more severe cases, of faradism, to the interior of the larynx."

The author's discussion of the pathogenesis of hysterical deafness on page 118 is interesting because he definitely postulates an organic change in the central nervous system for this condition. "In hysterical deafness the patient is so convinced that he cannot hear that he does not listen. Although the sound vibrations reach the ear in the normal way, they do not give rise to the slightest auditory sensation because of this inattention. The synapses at one or more of the cell-stations in the auditory path to the cerebral cortex must, therefore, be unswitched, probably as a result of retraction of the dendrons. In absolute hysterical deafness the auditory motor reflex, which is a function of the mid-brain, may be abolished or greatly diminished. One of the unswitched synapses must, therefore, be below the mid-brain and either in the auditory nucleus or less probably in one of the intermediate cell-stations—the superior olive or the nucleus of the lateral fillet." Suggestions, therefore, produce an unswitching of the synapses which can be cured by suggestion or persuasion. Surely this is an interesting theory.

H. A. Reye.

Libraries of the American State and National Institutions for Defectives, Dependents and Delinquents. By Florence Rising Curtis, M.A. Minneapolis: University of Minnesota, 1918. 56 p. (Studies in the Social Sciences 13)

Miss Curtis, in this brief yet comprehensive study of her subject, has made a real contribution to the cause of mental therapeutics as well as to the understanding of this most important but perhaps not generally known phase of special library work—institution libraries. Probably not many librarians even are acquainted with the development of this phase of library work which has taken place almost entirely within the last fifteen years.

The writer introduces her subject with a brief historical sketch of state and national institutions, and outlines the inherent problems of employment, education and recreation for inmates.

In Chapter II, she discusses the place of the library in the various types of institutions. "The advocate of the insane hospitals," says Miss Curtis, "will meet several objections from those who have not given the subject careful attention. These objections are usually three: first, that the insane through the nature of their affliction are mentally incapable of receiving any real benefit from books; second, that so many are disturbed and violent that books will not be safe in their hands; and, thirdly, that a library is an unnecessary fad, purchased at considerable expense for those whose comfort and well-being are in no way dependent on its use."

In refuting the first of these objections, Miss Curtis quotes statistics to show that many patients suffering from mental disease are by no means illiterate nor lacking in the ability to appreciate literature and art. Probably one fifth of all admissions are cases of manic-depressive insanity, which is periodic in nature, with, frequently, long intervals of mental health. This type of patient is very dependent upon reading for relief from depression and for the purpose of taking his mind off himself. Nearly a quarter of all cases admitted suffer from dementia praecox, the mental disease of the adolescent and of the young adult. Many of these patients have been youths of unusual intelligence and promise. In such cases occupational and educational interests may prevent complete dementia. Reeducation is now a feature in the care and treatment of patients in some institutions for the mentally diseased. It has been found that nature study makes an especially direct appeal and has proved very beneficial because it trains the observation and affords the student outdoor exercise. Needless to say, books on birds, flowers and trees aid greatly in arousing and holding the interest of the patient in the subject.

In refutation of the second objection—that patients are likely to mutilate or destroy books—Miss Curtis quotes statements by authorities to the contrary. Many hospitals record a careful handling of books of which any public library would be proud.

To refute the third objection—that money used for such libraries is an unjustifiable expenditure—the writer bases her argument upon the records and statistics of various institutions, from statements of institution librarians, attendants and physicians and from letters of patients—the most convincing evidence that the institution library plays a very important rôle, not only as a form of recreation, but also as a remedial agent. Dr. Max Witte, superintendent of the state hospital at Clarinda, Iowa, says: "If we should be permitted to come back in one hundred years, no doubt we should find the librarian acting under the direction of a physician and occupying a very important position in the treatment of the insane, more particularly in the earlier forms of insanity. . . ."

Books in institutions for mental defectives are, needless to say, largely juvenile fiction and fairy tales, with some travel and biography for the more intelligent, and picture books for those of more limited mental ability.

In institutions for juvenile delinquents books are a veritable saving grace. Many a young scapegoat has had his interest in questionable escapades and bad companions diverted to wholesome sports, inventions or nature study by the proper kind of reading. To the wayward girl an interest in books often becomes a pleasure and also a protection, the latter especially if she is thrown upon her own resources, when the public library affords not only recreation but a refuge from temptation and the advances of undesirable associates.

Statistics compiled from the records of reformatory and prison libraries, of institutions for inebriates, the tuberculous, dependent children, the blind, the deaf and the disabled, of homes for soldiers and sailors and their wives and widows all testify to the importance and value of well-organized, well-equipped and efficiently administered libraries.

Miss Curtis next outlines the history of the movement for state supervision of institution libraries, from 1905, when the first concerted effort for efficient service was made by the Board of Control and the superintendents of the various institutions of Iowa. Up to this time, some institutions had possessed book collections, a few of which had been classified and catalogued. In 1897 the New York State Library had published a list of books for the libraries of institutions for the mentally diseased. This was followed by the publication in 1917 of the first section of a list of books for prison libraries. In 1913, the Minnesota Board of Control created the position of Supervisor of Institution Libraries. Nebraska was the next state to take this step. In several other states the library commissions or similar agencies assume the supervision of institution libraries. The institution libraries of Indiana are testimonials to the efficacy of such a system when properly administered.

The administration of the institution library is discussed from three points of view: the book collection and the book fund, the library room, and the library service. This chapter is full of valuable suggestions for the institution librarian.

Chapter V traces the activities of library associations in regard to institution libraries, from the appointment in 1908 by the League of Library Commissions of a Committee on Library Work in State Institutions through the recent work of the American Library Association, which has included a survey of institution libraries in the United States, various publications, and the making of a collection of pictures of institution libraries to be used at state charities and corrections conferences and as a reference collection to be loaned to superintendents or others interested.

The last chapter in the book treats of the future development of the institution library. Miss Curtis presupposes that such a library will always be under the board of control, the library commission or a similar agency. "If placed under the library commission, the work has the advantage of continuity with the other library interests of the state: the executive officer of the commission is alive to the possibility of further service and the connection promises permanency, a cooperation in the use of books and other collections, and the influence of accepted standards in regard to records and equipment. On the other hand, if the institutions have been placed under the board of control it would seem that the supervision of the institution libraries might well be considered the duty of an officer of the board; in either case, there should be a supervisor, whose authority should come from the board of control.

"Realizing the special problem of the institutions, the superintendents in Iowa, in 1905, and again in 1911, urged the selection of a woman for the office. The reformatory and the prison are the only institutions where a different choice might be urged; experience has shown that the solution lies in the appointment of a woman of maturity and judgment, as well as education and training, and experience in her chosen field. In order to secure such an incumbent of the office, the salary paid should range from $1,500 to $2,000 per annum. Both economy and efficiency would be increased if suitable headquarters were furnished and the work was centralized. . . . This plan would presuppose office room and clerical and other assistance when necessary.

"The library of such institutions should be a separate department, recognized in the budget by a regular annual appropriation, and the statistics of its growth and use included in the annual report of the superintendent. There should be a minimum of 1,000 volumes for each institution."

A comprehensive bibliography follows the text of the monograph.

In the preface of Miss Curtis' pamphlet, written by Arthur J. Todd, Professor of Sociology in the University of Minnesota, the following statement is a just tribute to the value and importance of the monograph. Professor Todd says: "In publishing Miss Curtis' study of institution libraries, I am sure the University of Minnesota is rendering a notable service, not only to libraries and institutions, but also to the general public which is still shockingly ignorant of how its institutions are really administered. This little volume stands unique in its field, as it brings together a large amount of first-hand material secured through original research, in addition to collating scattered papers on single phases of the problem. It administers a definite refutation to the popular fallacy that institution libraries are a fad and that inmates of such institutions cannot and will not make use of them."

MABEL W. BROWN.

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MENTAL HYGIENE will aim to bring dependable information to everyone whose interest or whose work brings him into contact with mental problems. Writers of authority will present original communications and reviews of important books; noteworthy articles in periodicals out of convenient reach of the general public will be republished; reports of surveys, special investigations, and new methods of prevention or treatment in the broad field of mental hygiene and psychopathology will be presented and discussed in as non-technical a way as possible. It is our aim to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials, and students of social problems will find the magazine of especial interest.

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MORRIS J. KARPAS

MENTAL HYGIENE

VOL. III JULY, 1919 No. 3

MENTAL AND NERVOUS CHANGES IN THE CHILDREN OF THE VOLKSSCHULEN OF TRIER, GERMANY, CAUSED BY MALNUTRITION.

SMILEY BLANTON, M.D.

Recently Captain, M. C., U. S. Army, American Army of Occupation

THE medical officers of the Department of Sanitation and Public Health, Civil Affairs, Advanced General Headquarters, under the direction of Colonel Henry A. Shaw, M. C., while studying the physical changes occurring in the school children of Trier, Germany, due to malnutrition caused by war conditions encountered so many complaints from teachers and school officials concerning the great mental deterioration of the children as shown by their poor school work, and the number of nervous disorders occurring, that it was decided to supplement the physical examination by a psychiatric study to determine, as far as possible, just what the conditions were. It was also desired to take advantage of the unusual opportunity, probably never offered before, to make a psychiatric and psychological study of several thousand children forced to subsist for three years upon a rigid and inadequate diet. Moreover, such a survey would make it possible to substitute for the necessarily biased and emotionally influenced judgments of the German teachers and officials the facts obtained from an analysis of all the factors in the case.

The psychiatric study was restricted to the children of the *Volksschulen*, numbering about 6,500, between five and a half and fourteen years of age, for it was between these ages that the changes in school children caused by malnutrition were found to be greatest. First it was necessary to discover the obvious changes,—the number of children who had failed to pass their grades one or more times, and the extent of mental deficiency, nervous and conduct disorders of all kinds; this would free the field for a closer study of the less obvious but nevertheless quite definite changes occurring in children who did not attract the attention of teachers because of retardation or some abnormality. Then it was desired to determine to what extent all these changes were caused by malnutrition due primarily to war conditions.

It was soon seen that the problem was primarily one for careful clinical observation rather than for psychological tests. Even had it been possible to give each one of the 6,500 children a psychological test this would have given only the degree of retardation and not the underlying causes; nor would such tests have shown the emotional changes or the extent of the neuroses and nervous diseases. Investigations along the following lines were carried out:

1. The *Rektors* of the *Volksschulen* were asked to pick out and send for examination, as follows:
    (a) All children who were retarded in their grades one year or more
    (b) Children who were abnormally "nervous"
    (c) Children who had any organic nervous disease
    (d) Children with serious conduct disorders,—i. e., persistent lying, stealing, etc.
    (e) Children suffering from symptoms of psychoses or neuroses,—i. e., children who acted queerly or seemed emotionally abnormal in some way.
2. Interviews with teachers and *Rektors* concerning mental and nervous changes occurring in the children during the war.
3. Observation of the children in the school, on the playground and in their homes, together with interviews with parents.
4. A survey to determine the number and type of speech defects occurring in the school children.
5. Psychological tests given to those children suffering primarily from malnutrition, to determine the specific changes in mental abilities such as comprehension, learning ability, memory span and quickness of the associations.

The retarded and abnormal children sent by the *Rektors* for examination were analyzed to determine fundamental and contributing causes, and were then grouped under the following heads, indicating the fundamental cause active in each case: "Feebleminded," "Border Line Defectives," "Dull Type," "War Conditions," "Malnutrition" and "Illness." Cases classified under the first three heads were those who would have been feebleminded, border line defectives or dull type even had they not suffered from malnutrition, the condition being due primarily to heredity. "War Conditions," "Malnutrition" and "Illness" were classified as environmental causes.

Such a grouping is of course not logical, for a child may be retarded and also suffer from conduct disorders and have a neurosis as well. This, however, was found to be the best practical grouping which would quickly show the conditions. The children were first grouped according to their chief symptoms and then classified according to the fundamental cause back of the symptoms. A child merely retarded was placed in this group and then further classified as feebleminded, border line defective or as suffering from malnutrition, etc.; but those suffering from a neurosis, conduct disorder, etc., were grouped under that head whether retarded or not. Retarded is not used here in any technical sense but is applied to children one or more years behind their normal grade.

HEREDITARY CAUSES

The term "feebleminded" was applied to children who would never be more than ten years of age mentally, the mental age being determined by some standard test for measuring the intelligence. The one used was the Binet-Simon Scale as revised by Professor Lewis M. Terman. The "Intelligence Quotient" was used to differentiate the different levels of intelligence; it is determined by finding the mental age by means of the above scale and then making a fraction in which the mental age is numerator and chronological age is denominator. A child of ten with a mental age of ten has a Quotient of 100; the Intelligence Quotient then equals Chronological Age. Border line defectives are those with a Quotient between seventy and eighty. A child of ten years with a mental age of seven—Quotient seventy—would be rated as a border line defective. "Dull type" are those with a quotient between eighty and ninety. Children with average intelligence have quotients between ninety and a hundred and ten, those with superior intelligence have quotients above 110.

ENVIRONMENTAL CAUSES

Following are some of the "War Conditions" causing retardation:

1. Children sent to live in country in order to get better food, and because of this missing so much of their school work that they failed to pass.
2. Relaxed discipline in the home because of illness or absence of father due to army service, or illness or absence of mother from the home during the day because she had to work to support the family while her husband was away.
3. Necessity for children to remain at home to care for younger children while mother was away working.
4. Lack of sufficient clothing. Before the war most parents were able to clothe their children properly, but since the war clothing prices have risen so that many parents cannot afford to buy sufficient clothing.
5. Older children often absent in the country where they go to beg or buy food from the farmers.

Children were grouped under the heading of "Malnutrition" only where this was the primary cause of the retardation. Those who had been absent from school for a considerable length of time due to illness of any kind were grouped under "Illness." Many of their illnesses were caused primarily by malnutrition. The most common affections from which the children suffered were, in the order of their frequency:

1. Influenza
2. Pneumonia
3. Tuberculosis
4. Middle ear disease

Children were recorded as "Tuberculous" only when they had been so diagnosed by some physician; many of these cases had been in tuberculosis sanatoria. It is to be noted in this connection that many children of the poorer class here had tuberculosis before the war.

Cases classified under "Combination" were children of poor nervous stock being naturally stupid but who might have managed to get along with their school work had they not suffered from illness or malnutrition or been subjected to "war conditions." In these cases there was a combination of hereditary and environmental factors.

METHOD OF INVESTIGATION

We were greatly aided in the study of the children through the help of a German interpreter assigned to help us by the German authorities. The German teachers, *Rektors* and school officials, it may be said in passing, were very courteous and spared no effort to help in any way they could. The interpreter was a trained educator who knew English thoroughly and this made it possible to discuss with the *Rektors* complex educational and psychological problems which it would have been impossible to do without the help of such an interpreter. An American nurse who spoke excellent German also assisted. Two enlisted men recorded the cases examined on specially printed blanks.

Each school was visited and all the children who were "retarded," "nervous" or who suffered from conduct disorders, psychoses, neuroses, or some organic nervous disease, were examined. The children were seen by classes. Those to be examined were usually brought into the examining room one by one and the teacher of the class was always present. He was asked the following questions concerning each child:

1. What work does the father do?
2. Is the family—very poor—poor—average—or well-to-do?
3. Are the parents—stupid—average—or very bright?
4. How many children are there in the family?
5. Is there a history of any nervous or mental disease, drunkenness or anti-social behavior in immediate family?
6. How many times has the child failed and why,—illness, stupidity, etc.?
7. Has the child any brothers or sisters who have failed or who are in feebleminded school?
8. What is teacher's impression of the child's work; is he uniformly stupid or is he bright when he is fresh and only stupid when tired? Is he active or inactive?

In the case of children not grouped under "Retardation," special questions were asked to bring out all the facts in the case. Usually the teachers were informed, by their *Rektors*, several days before our visit to the schools, so that they could find out all the above facts about the children to be examined. In most cases we were able to get the facts since most of the teachers knew the families of the children they taught. After hearing the teacher's statement we formed our general impression of the child and supplemented this when necessary by a few simple tests taken chiefly from Professor Terman's Revision of the Binet-Simon Scale. By this method a very accurate judgment of the mental status of each child could be made. In doubtful cases the child was always given the benefit of the doubt. If we were not sure a child was feebleminded he was called a Border Line Defective; if not absolutely sure he was a Border Line Defective he was called a Dull Type.

The following typical cases taken from our record cards show how, by a brief examination lasting only a few minutes, enough facts were obtained to group the cases accurately under their proper headings.

Feebleminded Case

Peter R. Eight years old. Repeated first grade. Will not pass this year. Family very poor; father an invalid; mother said to be grossly immoral. Two brothers in the feebleminded school. Child cannot yet read or write. Teacher says he cannot learn; he is very inactive, sits quietly all day and never fidgets about. The child is very stupid in appearance. Cannot do the tests designed for six-year old children.

Cases with such a record we did not hesitate to say were retarded due to inherited feeblemindedness. Cases similar to this but with a lesser degree of mental deficiency were classified as Border Line Defectives.

Dull Type

Wilhelmina P. Aged nine years, six months. Second grade. Repeated first grade. Will pass this year but doing very poor work. Family intelligent. Father a glass blower, makes good wages. All the children are slow. Sister and three cousins all retarded. Child works hard but is slow of comprehension. Development poor—nutrition very poor. Appears slow and stupid.

The child is not a mental defective and yet we believe she would be dull and stupid, probably retarded a year or two, even if well nourished. This type of case was rated "Dull Type," although judging from the child's appearance and school work she appeared to be a Border Line Defective. The malnutrition had still further lowered what would be normally a low intelligence level.

In individual cases it was difficult at times to eliminate all the other causes that might be present and say that the retardation was due primarily to poor nutrition. However, children with histories such as the following were classified as being retarded due primarily to poor nutrition.

Retardation due to Malnutrition

Angelica M. Aged eight. First grade. Retarded two years. Family intelligent. Father was a teacher, now away in the army. Mother ill. Eight children in the family. Child is bright during the first school hours, soon grows tired, becomes inattentive, comprehends poorly, falls asleep often in school. Child is very thin and poorly nourished. About the size of a four-year old child.

PEOPLE OF TRIER

A brief discussion of the organization of the schools of Trier, the changes which occurred because of the war, and the food conditions in the city during the past three years will be necessary in order that we may determine just how much of the retardation was due to malnutrition caused by the war.

The city of Trier is situated on the Moselle River and is the center of the wine industry for the Moselle Valley. It has about 55,000 inhabitants, the majority of whom are small shopkeepers, artisans and officials. There are several thousand factory workers in about thirty factories which include leather and tobacco factories and iron foundries. The rich people are chiefly wine merchants, many of whom have grown quite rich during the war. Before the war there was much wine drinking among the poorer classes and much hard liquor was consumed as well. The people have large families and among the poor people malnutrition was common before the war. On the whole I believe we are justified in saying that the people of Trier are not so well developed physically and not so well off economically as the people in the neighboring cities of Cologne, Bonn and Coblenz.

FOOD CONDITIONS DURING THE WAR

It became difficult for the poor people to get bread in the winter of 1915 because the price was so high; and in March 1915 the German Government took over all the grain and the population was put on a bread ration. The composition of bread was not changed at this time. Gradually, however, the composition became poorer; the grain was milled higher and at times potato flour was mixed with the rye flour. For the last year of the war the bread, which was the chief article of the people's diet, was made from rye flour which contained ninety-five per cent of the raw grain. Such bread contains a great amount of waste material and causes digestive disturbances in the young or old. In a report on the food conditions in Germany during the war, Professor Max Rubner, the German physiologist says: "Full grain bread ground out to ninety-five per cent causes a loss as high as forty per cent of the nitrogen introduced and 14.8 per cent of the calories, even in the case of strong and healthy men accustomed to a rougher fare." The nitrogen and caloric loss must be much larger than the above in children.

After the rationing of the bread other articles of food were rationed as the prices rose until by 1916 every variety of food, save green vegetables such as cabbages, carrots, etc., was rationed. The official ration, as shown by Major C. C. Mason, during the winter of 1919 had a caloric value of only 1400 calories, "only two-thirds of the average requirement for basal metabolism." Even as early as 1916 the official ration was inadequate though not so bad as at present. At times the people of Trier were not able to get even the official ration. After the failure of the potato crop in the summer of 1916 there were weeks and even months when the people had to substitute for potatoes the indigestible *Steckrüben* in the digestion of which there is, according to Professor Rubner, a 66.2 per cent nitrogen and a 21.95 per cent caloric loss.

AMOUNT OF MILK OBTAINED

An adequate milk supply has so much to do with good nutrition that the amount obtained by the children of Trier was carefully noted. The amount of milk used by the city of Trier in peace times was 18,000 liters a day. The amount available was constantly reduced as the war continued until in the winter of 1917 the city received only 3,300 liters a day. According to official regulations in force in October 1916 the following people were supposed to receive the following amounts of milk in the following order of priority:

1. Children 0–2 years	1 liter
2. Pregnant women	$\frac{3}{4}$ "
3. Sick	$\frac{1}{2}$–1 "
4. Children 2–4 years	$\frac{3}{4}$ "
5. " 5–6	$\frac{1}{2}$ "

To fulfill these ration requirements 11,300 liters of milk a day were needed. Since 1916 this amount of milk has not been available; hence the children above two years of age received only small amounts of milk and often none at all. In the survey made by Colonel Bruns and Captain Hartman, U. S. Army, Department of Sanitation and Public Health, American Occupied Area, the food of 2413 school children was recorded and only sixty-eight had milk as a part of their diet. For three years the children have subsisted on a diet in which the protein was of a vegetable nature not readily assimilated. They lacked animal protein and butter fats. According to the statement of Major C. C. Mason there has been in the case of children a twenty-five per cent decrease in caloric needs and a fifty per cent decrease in the protein needs of the body.

The official ration being inadequate to prevent malnutrition and actual starvation, the people were forced to seek food outside of the ration. Green vegetables were not rationed and were easily obtainable but even this addition was not sufficient. More substantial food had to be obtained; chiefly from the farmers who unlawfully held back part of their produce which they were supposed to turn over to the government at a fixed price. The success of people in obtaining extra food depended on their economic status. Those with money could always obtain food, such as butter, eggs and meat, even at the worst period of the food shortage. Even the very poor were able to buy some extra food; fortunately many of them had relations who were peasant farmers and in this way they were able to get from time to time a little butter, a few eggs, or some potatoes. As will be shown one of the chief reasons why the older children were often absent from school was because they were away in the country buying or begging food from the farmers.

Most of the poorer classes, however, were not able to get enough extra food to make an adequate diet. The diet of the children in the average family consisted of the following: Breakfast—ninety-five per cent rye bread, marmalade made of turnips usually, and the lowest grades of syrup from beet sugar refineries; Ten O'clock Meal—bread and marmalade; Midday Meal—potatoes, war soup containing little or no fat or potatoes, and perhaps bread; Four O'clock Meal—bread and marmalade; Six O'clock Meal—potatoes, soup and bread. On Sunday, meat and butter or oleomargarine were to be had. Following is a list of the official ration for each person for the city of Trier during three two-week periods:

Best 2-week period—2nd to 16th June, 1918

¼ lb.	Indian Meal
¼ "	Potato starch
40 gr.	Bouillon substitutes
¼ lb.	Butter
⅛ "	Barley
⅛ "	Sausage
⅛ "	Grits
310 gr.	Sugar
1 liter	Milk
¼ lb.	Barley meal
⅛ "	Noodles, vermicelli
1 "	Soup substitutes
4 "	Rye bread

Average 2-week period—6th to 19th October, 1918

310 gr.	Sugar
¼ lb.	Butter
⅛ "	Cheese
⅛ "	Barley
¼ "	War soup
1	Herring
1 lb.	Onions
⅛ "	Sago
4 "	Rye bread

Poor 2-week period—9th to 22nd March, 1919

310 gr.	Sugar
¼ lb.	Flour
1 "	Coffee substitute
50 gr.	Margarine
⅛ lb.	Vermicelli
¼ "	Barley
50 gr.	Butter (Those who got butter did not get margarine.)
4 lb.	Rye bread

Ingredients for bread; marmalade, artificial honey, jelly, one of these three things, ½ to 1 lb. a week. War soap, 50 gr. a month.

In judging then the findings concerning the mental and nervous changes found in the children, it may be taken for granted that from forty to fifty per cent of the children have suffered from a noticeable degree of malnutrition for a period of at least two and probably three years.

CONDITIONS IN SCHOOLS OF TRIER

There are fifteen *Volksschulen* in the City of Trier and one *Hilfschule* (feebleminded school). In all there are about 6800 children in the schools between the ages of five and a half and fifteen years.

Most schools have six classes: the first school year is called the sixth class, and in the first class, where the children remain three years, are mixed the sixth, seventh and eighth grades. It is, therefore, often difficult to determine whether a child is in the sixth, seventh or eighth grade. A child is usually kept in a class two years and if he does not pass he is promoted anyhow. Promotion is often determined by the size of the room and the number of the children in the class. If the class is too large children are promoted whether they pass or not. The classes are very large, the average numbering fifty to seventy children. This is not due to war conditions but was so before the war.

A rather constant complaint met with is that the children do not master their work as they did in pre-war days. In determining just how much of this poor work is due to malnutrition and how much to other causes, the following conditions which tended to disorganize the schools during the war must be considered:

1. The city of Trier was one of the German cities nearest the front; thousands of troops were stationed in the town; troops were constantly passing through on their way to or from the front; the city was often flooded with the wounded after the great offensives. All of this created an atmosphere of unrest that communicated itself to the children and interfered with their school work. 2. In the home of the average German the discipline is quite rigid, but with the father away at war there was no one to maintain the old standards and the home work of the children suffered. If they did not get their lessons there was no one to make them. 3. The town was bombed twenty-two times—and the air alarm was sounded 97 times. Most of these raids or alarms occurred during the year 1918. The air alarm often occurred during the school hours and the children and teachers had to seek shelter in the cellar. So frequent were the alarms during 1918 that the children could not pay attention to their work for they were always waiting for the alarm to sound. 4. The schools were often occupied by soldiers, at one time more than one-third of the schools being used as barracks. This made it necessary to crowd the children of two schools into one, to shorten hours, and to eliminate part of the work altogether. 5. During the last two years of the war there was a coal shortage and the schools had to be closed sometimes for a whole month at a time. During these periods the children formed habits of idleness that it was hard to overcome. 6. When the war began there were 128 teachers in the *Volksschulen*—about half of whom were men. More than thirty of these men were taken by the army, and they

were replaced by women with little pedagogical training. The net loss of teachers due to the war was never more than ten. But the absence of experienced men teachers from the schools had some influence in causing the poor work of which the Germans complain.

FINDINGS OF SURVEY

It was intended, as explained before, to group the children examined under such types as they appear to the teacher in the schoolroom. The teacher does not usually make fine psychiatric or psychological distinctions; children are "retarded" because of "stupidity" or "laziness" or "absence" or "illness"; they appear "nervous" or they misbehave, or seem "peculiar," or act in an abnormal manner. Chart I shows that most of the children referred for examination were merely retarded. Out of 1051 cases 94.8% were sent for examination because they were retarded in their grades one or more years. The percentage of retarded in the whole school population is 15.3%. This is five to seven per cent larger than is to be found in the average school population under normal conditions. Only part of this increase can be attributed to malnutrition; "war condition" and disorganization of the schools were also responsible for part of this increase of retardation. In order to make a comparison of retardation before and during the war the following figures were obtained from the *Schulrat* of Trier, giving the percentage of children failing to pass their grades during the years ending April 1, 1912, 1914, 1918 and 1919:

Year ending April 1	*Percentage of failures*
1912	8%
1914	8%
1918	15%
1919	14%

We estimate that about half of this increase of percentage of failures during the war was caused by malnutrition, the other half being caused by "war conditions" and disorganization of the schools.

It is very interesting that all the cases grouped under the term "abnormal"—the "nervous," conduct disorders, organic nervous diseases, psychoses and neuroses—totaled only 5.2% of the number recorded, and only .85% of the total school population. Judging from the statements of the teachers and school officials we expected

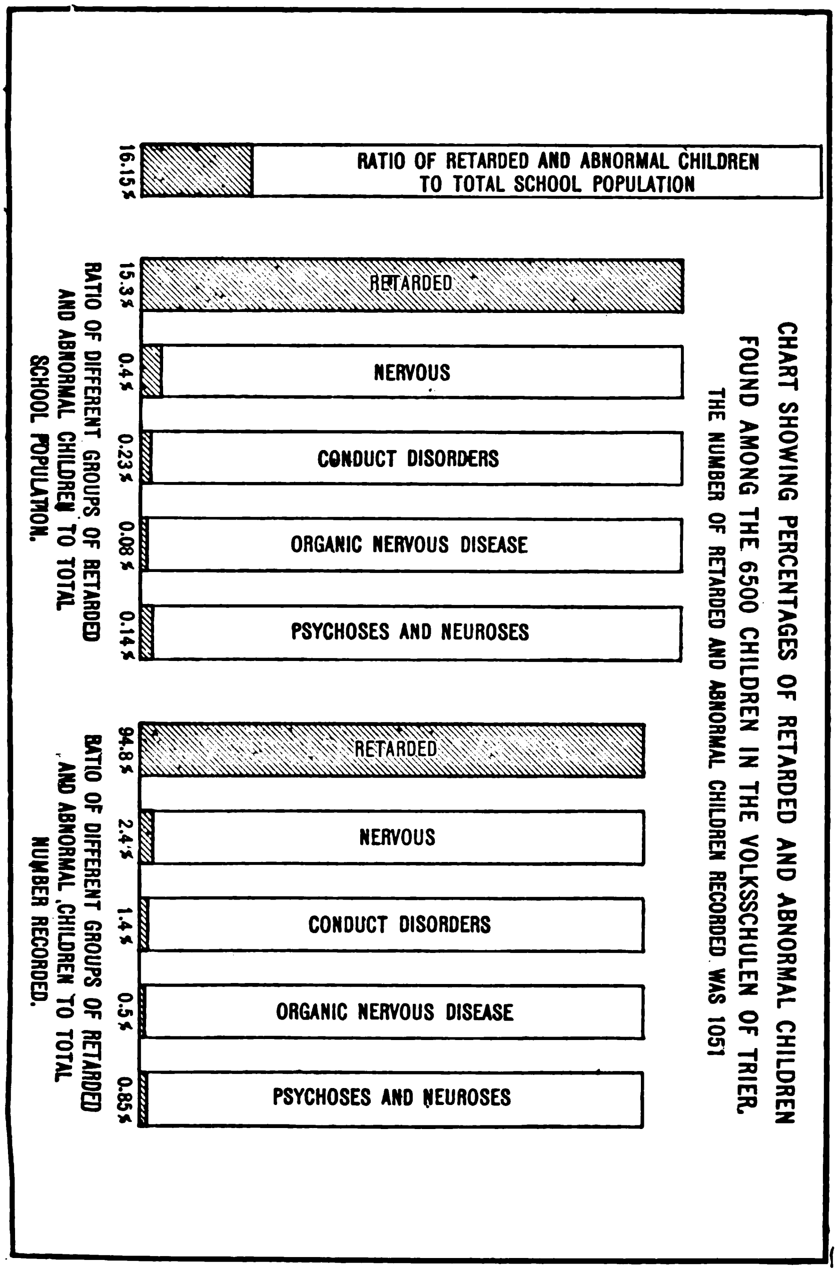


CHART SHOWING PERCENTAGES OF RETARDED AND ABNORMAL CHILDREN
FOUND AMONG THE 6500 CHILDREN IN THE VOLKSSCHULEN OF TRIER.
THE NUMBER OF RETARDED AND ABNORMAL CHILDREN RECORDED WAS 1051
16.15%
RATIO OF RETARDED AND ABNORMAL CHILDREN TO TOTAL SCHOOL POPULATION
15.3%
RETARDED
0.4%
NERVOUS
0.23%
CONDUCT DISORDERS
0.08%
ORGANIC NERVOUS DISEASE
0.14%
PSYCHOSES AND NEUROSES
RATIO OF DIFFERENT GROUPS OF RETARDED AND ABNORMAL CHILDREN TO TOTAL SCHOOL POPULATION.
94.8%
RETARDED
2.4%
NERVOUS
1.4%
CONDUCT DISORDERS
0.5%
ORGANIC NERVOUS DISEASE
0.85%
PSYCHOSES AND NEUROSES
RATIO OF DIFFERENT GROUPS OF RETARDED AND ABNORMAL CHILDREN TO TOTAL NUMBER RECORDED.

CHART I.

to find a much larger percentage. Also it was expected that the bombing and the many air alarms, the relaxed discipline, the strain of the war conditions and the increased irritability and lowered resistance due to three years of malnutrition affecting at least half the children, would cause an increase in the type of cases mentioned above, especially children having tics of some sort. This was not the case. Only fifty-four cases of this kind were found in 6500 children and this is probably less than would be found in a similar number of American school children. When it was seen what a small number of such cases were being referred it was thought that the teachers did not understand and it was explained to them again that all these cases should be sent for examination. It is, therefore, quite certain that no mistake was made and that all the cases were seen. We believe that it can be definitely stated that the war—and particularly the malnutrition—has not caused an increase, to such an extent as to appear definitely abnormal, in the number of children suffering from neuroses or psychoses, conduct disorders, organic nervous diseases or general "nervousness."

Only twenty-five children or .4% of the total school population were referred to us for being extremely "nervous." The air raids and alarms seemed to have been the chief cause in four of these cases. Fourteen were apparently due to malnutrition, eight were due to illness and one to war conditions. A typical case due to poor nutrition may be given:

Joseph U. Aged ten years, eight months. Fifth grade. Father away in the war. Mother works. Family very poor. Get very little food beside the ration. Child cannot sit still. Has a tic of the facial muscles. When he tries to reply to questions as to his age and where he lives he becomes so nervous and trembles so that he cannot speak. Teacher says child is this way when he tries to recite. Not an actual stutter—just a general nervousness and trembling. Child is not stupid and does his school work well. Child is in wretched physical condition, poorly developed. Classified: "Nervous case." Cause: Poor nutrition.

Another case is that of Helena V., which might have been classified under the neuroses but was placed here because "nervousness" was such a prominent symptom.

Helena V. Aged eleven years, five months. Fourth grade. Father a prisoner of war in France for two years. Mother suffering from a mental breakdown, seems to be a manic depressive attack, depressive phase,—in bed all the time. Family very poor. Supported by the city. Child is very bright. Does good work. She cries often. Worries about her father. Cries in school when the war or her father is mentioned Generally very "nervous." Was quite all right until her father was captured. Nutrition is very poor. The chief cause here seems to be the child's worry about her father, so the cause given was "war conditions."

Although there are only a few "nervous" cases with marked symptoms, there are a good many children who suffer from mild symptoms as was discovered by visiting in the homes and talking with the parents of the children. Many have terrifying dreams about air raids, many sleep poorly and are "nervous" about going to bed. Some children worried a great deal about their fathers who had been killed or captured; many of them cried whenever the war or their fathers were mentioned. The condition of these children has much improved since the war ended. It seemed remarkable to us, and contrary to our expectations, that the frequent bombing and air alarms and the often tragic deaths of fathers or brothers should cause so little "nervousness," so few neuroses among the children. There was, however, a general nervous restlessness noticed in the schoolroom, the significance of which will be discussed later.

Only fifteen children suffered from conduct disorders; these consisted chiefly of truancy. Four boys organized a gang to steal from the American Commissary. It was astonishing to find cases of this type so few. We had been told by Germans that terrible conditions existed; gangs of thieves, composed of children twelve to sixteen years of age, were said to roam the streets. Because of the absence of fathers in the war many children, it was said, had become thieves and truants. This is not the case in Trier, and is not the case, as far as could be determined by talking with the school authorities, in the Rhenish cities—Cologne, Coblenz, and Bonn. In the juvenile court in Trier there has been no record of any increase in juvenile delinquency. We feel safe in saying that in 6,500 American school children more than fifteen cases of conduct disorders would be found. It speaks well for German discipline that so little misbehavior occurred in the children exposed for four years to the disintegrating influences of war.

Only two children were found suffering from neuroses. Both of these were nervous, timid girls who reacted to the death of their fathers in the war with a neurosis. There were undoubtedly other children beside these with neuroses but their symptoms must have been so mild that they did not attract the attention of the teacher, nor were they apparent to us during the survey. Some of the cases rated as "nervous" were neuroses whose chief symptom was general nervousness. Since so few cases turned up it is clear that even allowing for a considerable error there must have been a very small percentage of children with neuroses.

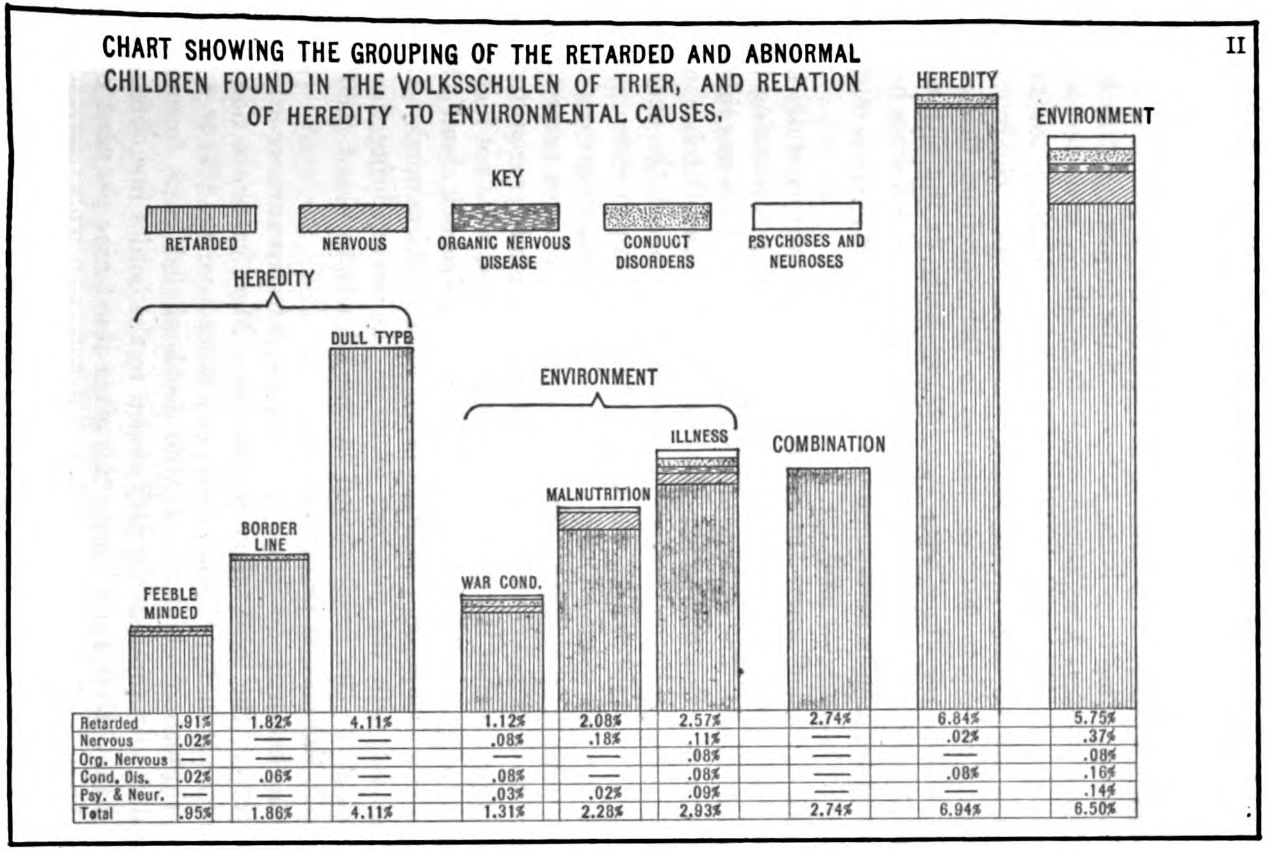
Only seven psychoses were recorded; one seemed to be an early dementia praecox, the other six were cases of idiopathic epilepsy having no relation to the war. There were only five cases of organic nervous disease, one hydrocephalus and four suffering from a paralysis due to an old attack of anterior poliomyelitis.

CAUSES OF RETARDATION

In Chart II are shown chiefly the causes for retardation and the relationship of environmental and hereditary factors. It will be seen that these two factors are about equal, indicating that fully one-half of the retardation was due to conditions having no relation to the war or the resulting malnutrition. Of the fifteen per cent retarded cases, more than seven per cent were due to hereditary causes, showing that it is a mistake to attribute all the changes in the school work of the children to war conditions or malnutrition.

The small number of retarded children due primarily to malnutrition was astonishing, only 135, or 2.08%, of the total school population. Most of the cases of illness however would never have occurred probably if malnutrition had not been present. But even if we add these cases—167, or 2.57%—to the cases due primarily to malnutrition it gives only 4.6% of the school population or about one-fourth of the cases examined. Malnutrition was the deciding cause of retardation in the cases classified "Combination." These children were of Dull Type, the kind that just manage to get along under favorable conditions. Under the influence of malnutrition they were unable to keep up with their class and had to drop behind. Since without malnutrition these children would not fail, these cases may be added to those due to illness or malnutrition. This gives 7.39% of the school population retarded primarily or chiefly through malnutrition. Even this is a surprisingly small percentage when it is considered that about half of the children are suffering from malnutrition, and that the condition existed for three years. The German school authorities say, however, that the number of retarded would be much larger if the school standards had not been relaxed. They claim that many children are promoted now who would fail under pre-war standards.

Seventy-three cases, or 1.31%, were retarded because of "war conditions." The causes have been noted as:—relaxed discipline, absence due to lack of clothing or because sent to live in country



	FEEBLE MINDED	BORDER LINE	DULL TYPE	WAR COND.	MALNUTRITION	ILLNESS	COMBINATION	HEREDITY	ENVIRONMENT
Retarded	.91%	1.82%	4.11%	1.12%	2.08%	2.57%	2.74%	6.84%	5.75%
Nervous	.02%	—	—	.08%	.18%	.11%	—	.02%	.37%
Org. Nervous	—	—	—	—	—	.08%	—	—	.08%
Cond. Dis.	.02%	.06%	—	.08%	—	.08%	—	.08%	.16%
Psy. & Neur.	—	—	—	.03%	.02%	.09%	—	—	.14%
Total	.95%	1.86%	4.11%	1.31%	2.28%	2.93%	2.74%	6.94%	6.50%

CHART II.

to get better food or because of necessity of staying at home to care for younger brothers or sisters. One of the chief causes of absence was the trips of the older children to the country to beg or buy food from the farmers. Children of twelve to fourteen went out twenty to a hundred miles in the country and were gone for days, going from house to house of the farmers, getting half a dozen potatoes here, another half dozen there, with perhaps an occasional egg or two. They slept in barns, on straw stacks and often begged their meals from the farmers. Some children were absent as much as three months in the year from this cause. The food conditions were so bad, especially in the autumn of 1916, after the failure of the potato crop, that the *Rektors* had to give the children permission to be absent for the purpose of going to the country for food.

In one school where the record of absences was carefully kept, and the percentages worked out, the following interesting facts were found. The average absences for the year 1918 was thirteen per cent. But during the months of August and October, when the early and late potato crops were being gathered, the absences averaged, respectively, twenty and twenty-two per cent.

Fifty-nine cases, or .95% of the school population, were diagnosed as feebleminded. It is usual to find a larger percentage, two to three per cent. The small number found is accounted for by the fact that the children in the *Hilfschulen* were not included in the survey. There are 120 children in this school, about 1.90% of the school population, most of whom are feebleminded. These together with the numbers found in the survey bring the percentage of the feebleminded in the schools to about 2.90%—about the normal percentage.

One hundred and eighteen border line defectives are recorded, or 1.82% of the total school population. More cases are classified under "Dull Type" than under any other heading, 267, or 4.11% of the school children. If the feebleminded cases found are added with those in the *Hilfschulen* to the border line defectives and the "Dull Type" cases this gives about nine per cent of the children suffering from mental deficiency. This percentage, somewhat larger than normal, is due to the number of dull children who because of malnutrition have become like border line defectives. Some of these "Dull Type" cases will rise out of the border line class when they are better fed; some have suffered permanent injury and will always have a lower level of intelligence. We may conclude that there has been a slight increase in the number of mental defectives, chiefly among the border line defectives. It is estimated that this increase is not more than one per cent of the school population.

School physicians often claim that children are feebleminded because of poor food and malnutrition resulting therefrom. It is possible that extreme malnutrition in infancy over a long period may so injure the nervous system that feeblemindedness may result. Children free from organic nervous disease and with parents of average intelligence very rarely become feebleminded through malnutrition, even of an extreme degree. One of the most important things shown in this whole study is how the nervous system of children of good nervous stock can resist malnutrition of an extreme degree extending over three years. But the feebleminded, the border line defectives and those classed as dull—the lowest twenty per cent of the population as regards intelligence with an intelligence quotient of ninety and below—are affected and often permanently so by malnutrition of even a moderate severity. These children, struggling along trying to keep up with the more fortunately endowed children, are affected by malnutrition almost as they would be by a blow on the head. The feebleminded drop to lower levels of intelligence. The border line defectives become like the definitely feebleminded and the normally dull children become like border line defectives.

How was it possible to determine what would be a child's normal status if he had never suffered from malnutrition—whether feebleminded, border line defective, or merely dull? If only a few cases were examined this would be difficult and conclusions drawn therefrom likely to be erroneous. However, when hundreds of cases are seen the chances of error are quite negligible. The normal mental status of a child was determined by the mental status of his parents and of his brothers and sisters and his general behavior. The assisting nurse obtained an accurate family and personal history of the case by visiting the homes of each child examined. A typical case is given of a child whose normal mental status should be that of a dull type but on testing graded as feebleminded.

John F. Aged ten years. Second grade. The teacher taught his father and mother. They were both retarded two years. Father is a waiter. Mother is said to be of average intelligence. Three brothers aged fifteen, thirteen and twelve years, all retarded, one or two years. Fifteen-year old brother failed two times before the war. Child is very poorly nourished. No organic nervous disease. Much undersized. He tested six years of age mentally by the revised Binet-Simon scale. He was uniformly dull during the test. In school the same. At no time does he show flashes of normal intelligence.

From the good family history it is estimated this child would probably under normal conditions have had a mental age of about 8 years. The other two years of retardation were considered to be due to poor nutrition. It would be most unusual for a child with this history, and with no organic nervous disease, to be of such a low level of intelligence. It is upon the feebleminded, the border line defectives and the "dull" and the "near dull," those children of poor and defective stock, that the malnutrition has had its greatest effect.

The effect of malnutrition on the physical and mental abilities of children, as shown by the survey, depends on two factors: on the severity of the malnutrition and the mental status of the child —whether a dull type or possessor of average intelligence or superior intelligence. Since the summer of 1916 the population has been subjected to a diet which has not possessed sufficient fats or easily digestible proteins. The children of well-to-do families had access to food supplies beyond the reach of the poorer classes and did not suffer. There were also variations in the malnutrition of children subjected to the same diet. Some children because of poor health or individual make-up were less able to assimilate the proteins—the coarse bread and the watery vegetables—and hence they suffered from a severer grade of malnutrition. Others became ill and after recovery did not get food suited to their condition and therefore fell permanently into a lower grade of malnutrition.

For these reasons this malnutrition varied among children:

1. Children of rich or well-to-do parents were able to buy much extra food.
2. Some children due to a physical weakness or individual make-up were less able to assimilate the coarse bread and watery vegetables.
3. Children who were convalescing after illness, unable to get food suited to their condition, dropped permanently into a lower grade of malnutrition.

Charts III, IV and V illustrate different phases of the survey findings. From Chart III it may be seen that the majority of the cases recorded were in the third grade and that more than seventy-eight per cent of the total cases examined were in the first four grades. This difference is not due to the smaller num-

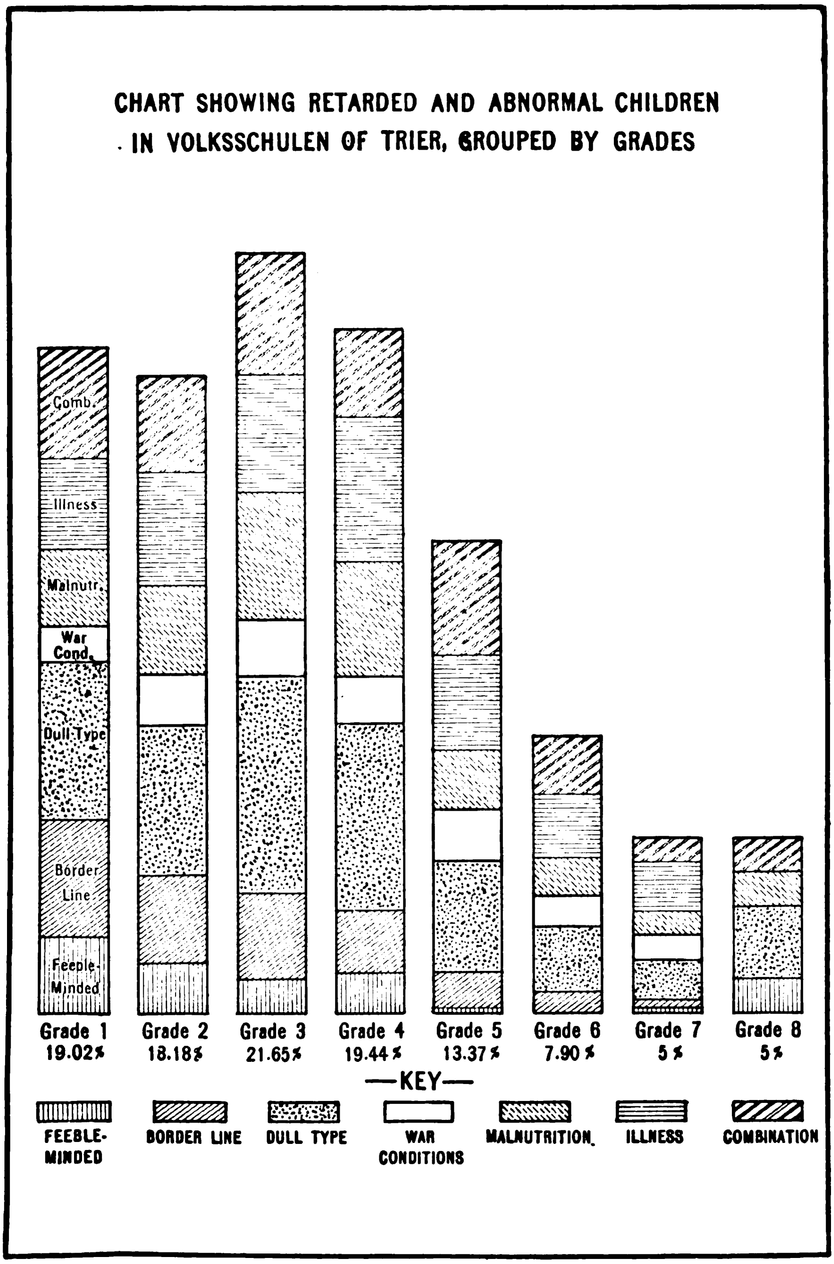


CHART SHOWING RETARDED AND ABNORMAL CHILDREN
IN VOLKSSCHULEN OF TRIER, GROUPED BY GRADES
Comb.
Illness
Malnutr.
War Cond.
Dull Type
Border Line
Feeble-Minded
Grade 1
19.02%
Grade 2
18.18%
Grade 3
21.65%
Grade 4
19.44%
Grade 5
13.37%
Grade 6
7.90%
Grade 7
5%
Grade 8
5%
—KEY—
FEEBLE-MINDED
BORDER LINE
DULL TYPE
WAR CONDITIONS
MALNUTRITION
ILLNESS
COMBINATION

CHART III.

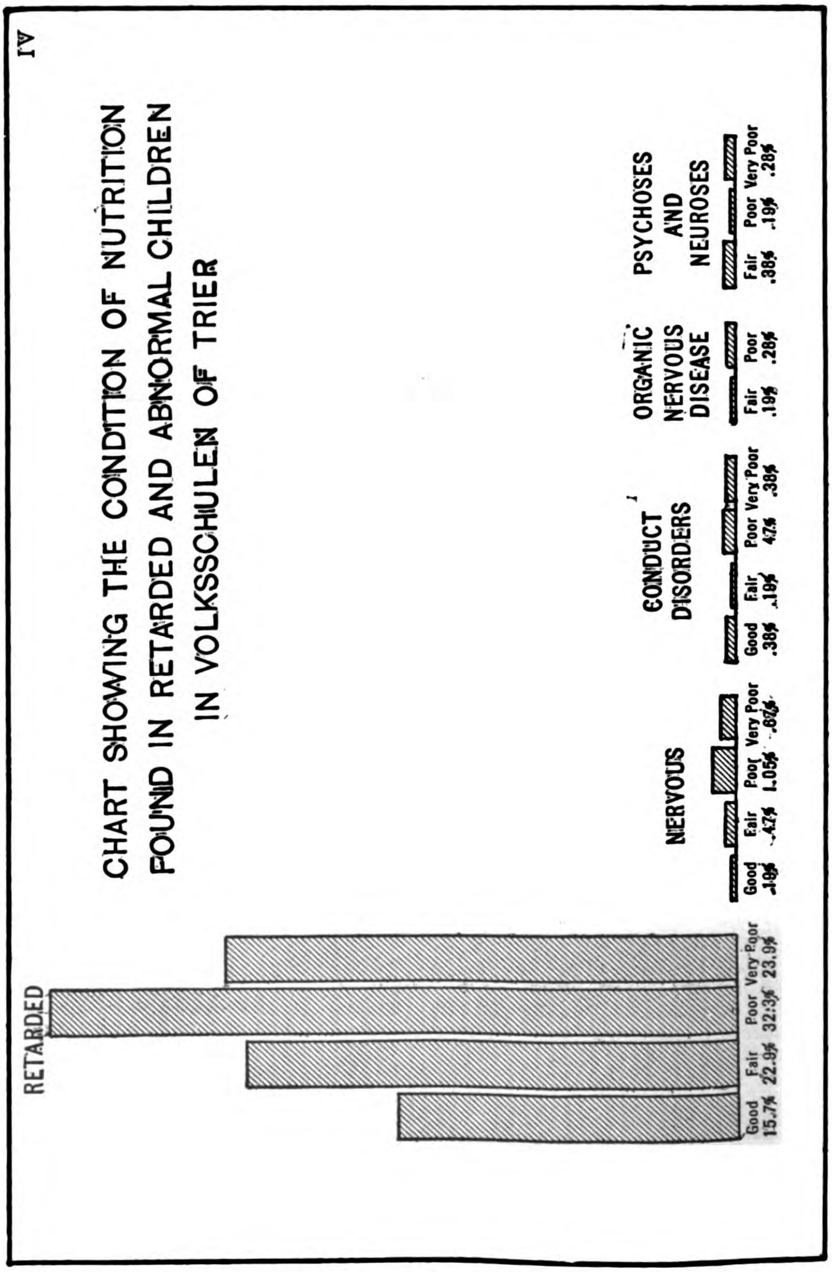

IV
CHART SHOWING THE CONDITION OF NUTRITION FOUND IN RETARDED AND ABNORMAL CHILDREN IN VOLKSSCHULEN OF TRIER
RETARDED
Good 15.7%
Fair 22.9%
Poor 32.3%
Very Poor 23.9%
NERVOUS
Good .19%
Fair .47%
Poor 1.05%
Very Poor .67%
CONDUCT DISORDERS
Good .38%
Fair .19%
Poor .47%
Very Poor .38%
ORGANIC NERVOUS DISEASE
Fair .19%
Poor .28%
PSYCHOSES AND NEUROSES
Fair .38%
Poor .19%
Very Poor .28%

CHART IV.

ber of children in the upper grades. School attendance is compulsory in Germany between the ages of six to fourteen. However, many of the feebleminded and border line defectives never reach the eighth grade even though they attend school until the age of fourteen. Some *Rektors* automatically promote these children—other keep them in the sixth grade. This grouping of the cases in the first four grades is due partly to the fact that malnutrition affected more seriously the children between the ages of six to ten than those between the ages of ten to fourteen; also partly to the fact that there are more feebleminded, border line defectives and dull cases in the lower than in the upper grades. There are about the same number of feebleminded in the first four grades; in the fifth, sixth and seventh grades there are practically none, most have been sent to the *Hilfschulen*. In the eighth grade a few again appear. These are cases that have been automatically pushed along. The "Dull Type," the cases of "Illness," those due to war conditions and those classified under "Combination," are about equal in all the grades. The cases due to malnutrition are greatest in the first four grades.

The nutrition of each child examined was noted as good—fair—poor—or very poor. Chart V shows that sixty per cent of the cases had poor or very poor nutrition, while forty per cent had good or fair nutrition. It is interesting to compare this with findings of the other survey made by the Department of Sanitation and Public Health concerning the physical condition of 2413 children. In this survey the condition of nutrition was determined by a physical examination and a hæmoglobin test. Of the 2413 children examined only about thirty-five per cent had poor nutrition, fifty-eight per cent fair nutrition and seven per cent good nutrition. The percentage of poor and very poor nutrition was almost twice as high among the defective and abnormal children as among the average children. Chart IV shows that only about thirty-eight per cent of the retarded had a nutrition that was good or fair. Many of these were feebleminded or border line defectives due to hereditary causes and having no relation to malnutrition. A majority of the cases classified as "nervous" had a poor or very poor nutrition.

SPEECH DEFECTS IN VOLKSSCHULER OF TRIER

Speech is a delicate thermometer of the emotional adjustment and the nervous coordinations of an individual. Especially in

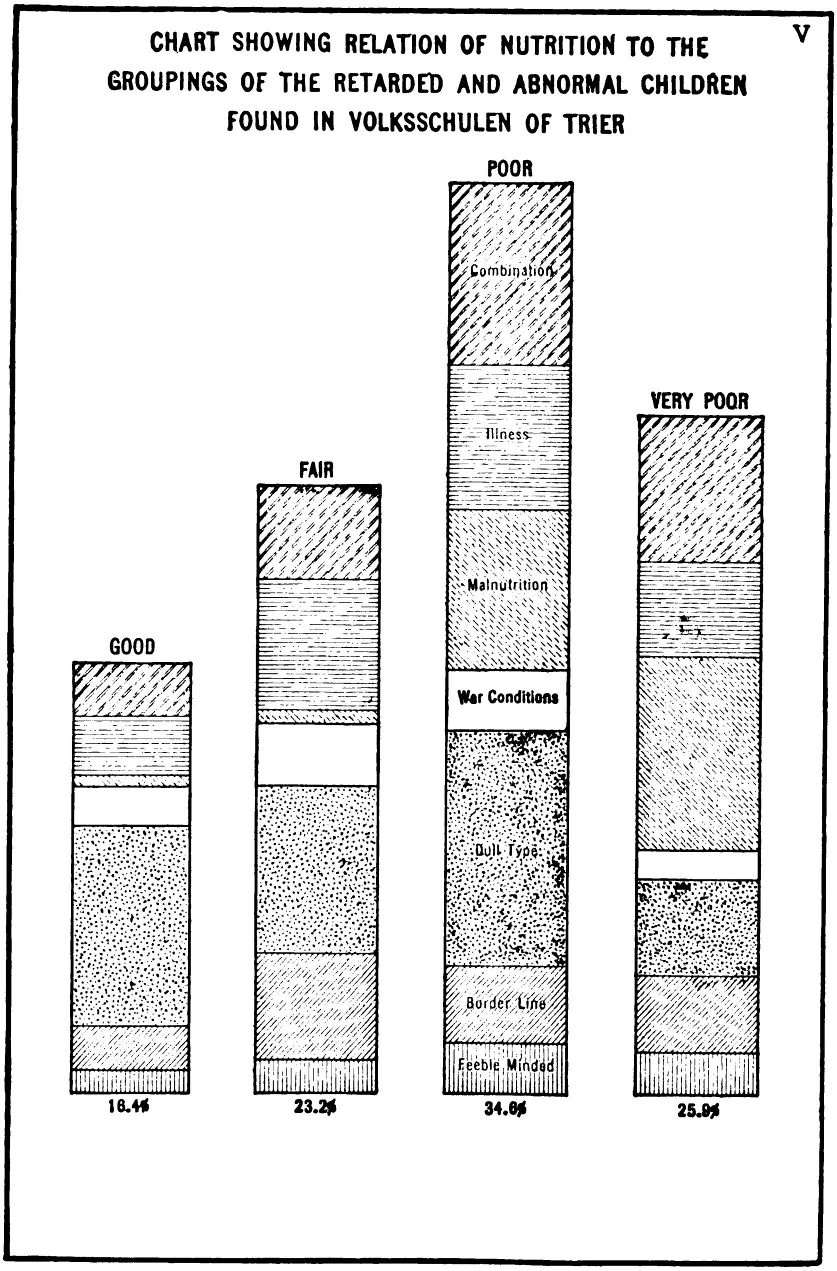

V
CHART SHOWING RELATION OF NUTRITION TO THE GROUPINGS OF THE RETARDED AND ABNORMAL CHILDREN FOUND IN VOLKSSCHULEN OF TRIER
GOOD
FAIR
POOR
VERY POOR
Combination
Illness
Malnutrition
War Conditions
Dull Type
Border Line
Feeble Minded
16.4%
23.2%
34.6%
25.9%

CHART V.

children is this true. Anything which causes emotional disturbances, any factor such as illness or malnutrition which interferes with the developing coordinations in the child, necessary for speech, will cause a defect of speech. Because of the increase of "nervousness" said to exist among the school children due to war conditions, air raids, etc., and the lack of development because of poor nutrition it was expected to find a large number of speech defects. Fortunately, from other surveys the percentage of speech defects found among children under normal conditions is known. A personal survey of about 5000 school children between six to fourteen years of age in the schools of Madison, Wisconsin, showed about five per cent had defects of speech. Of the whole .75% were stutterers.

The survey of the children in the schools of Trier was also a personal survey. Each child was asked to repeat a simple sentence in German containing most of the commonly used vowels and consonants. Those discovered to have speech defects were given a further examination to test the speech coordinations. Children were not recorded as having speech defects unless the defects were very definite or quite noticeable. An exception was made in the cases of stuttering; all such cases were recorded. Slight lisps—poor speech—a tendency toward baby talk—were not recorded. Five types of defects were recorded: stuttering —this term included so-called stammering; lisping which included all forms of letter substitution as well as the slurring and incorrect formation of "s," "z" and "th" sounds; thick speech, the speech which is heard in its most typical and extreme form in the grossly retarded—those classified as "imbeciles" with a mental age below 8 years; indistinct speech, which may be described as a retention of an extreme type of the slurring, indistinct speech of babyhood; cleft palate, in which there is a defect of speech that is characterized by extreme nasality.

Three hundred and twenty-three cases of speech defects were found—five per cent of the children—the same percentage found in the children of Madison, Wisconsin. The number of stutterers among them was sixty or .92% of all the children. The usual proportion of stuttering, boys to girls, was found, three boys to one girl. If the children were very nervous and suffering from emotional instability the percentage of stutterers should be increased, but there was no increase in percentage of stutterers normally found.

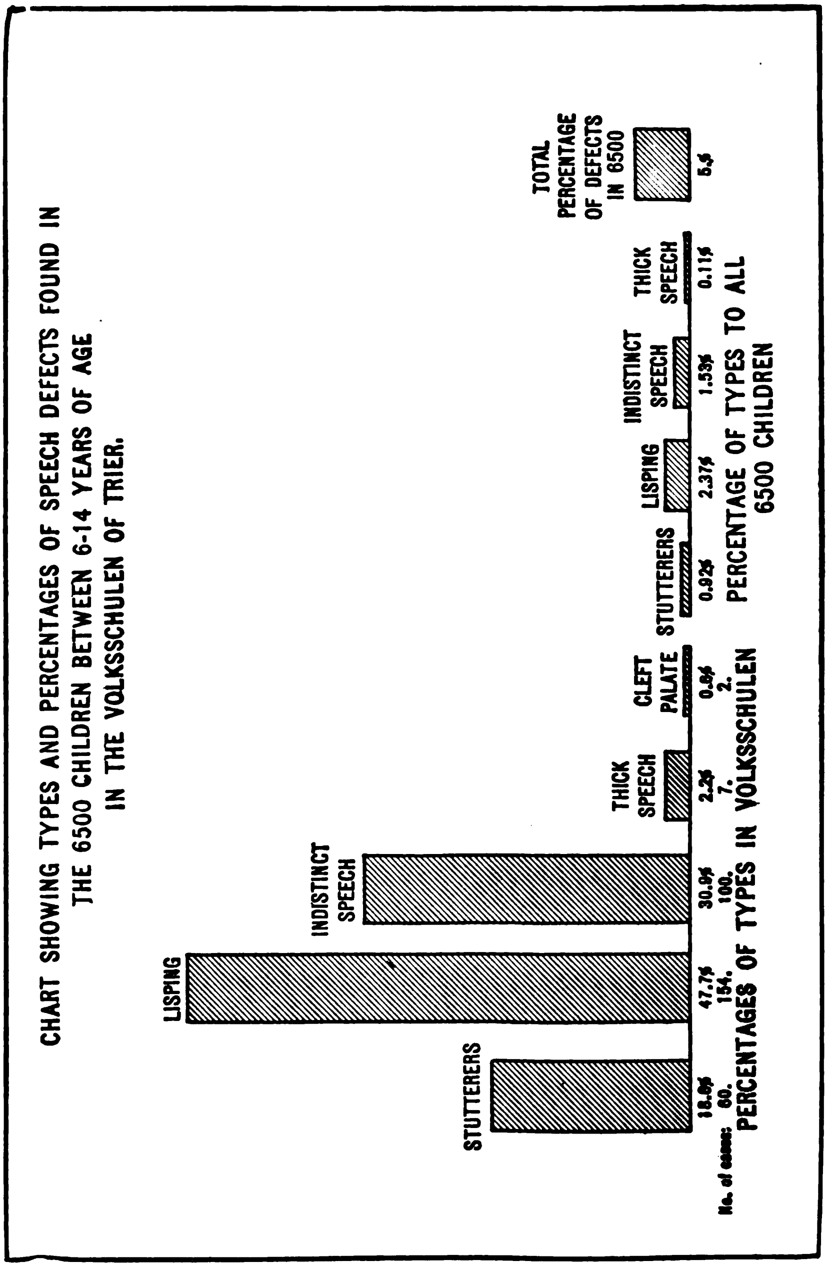


CHART SHOWING TYPES AND PERCENTAGES OF SPEECH DEFECTS FOUND IN THE 6500 CHILDREN BETWEEN 6-14 YEARS OF AGE IN THE VOLKSSCHULEN OF TRIER.
STUTTERERS
LISPING
INDISTINCT SPEECH
THICK SPEECH
CLEFT PALATE
No. of cases:
18.6%
60.
47.7%
154.
30.9%
100.
2.2%
7.
0.6%
2.
PERCENTAGES OF TYPES IN VOLKSSCHULEN
STUTTERERS
LISPING
INDISTINCT SPEECH
THICK SPEECH
0.92%
2.37%
1.53%
0.11%
PERCENTAGE OF TYPES TO ALL 6500 CHILDREN
TOTAL PERCENTAGE OF DEFECTS IN 6500
5.%

CHART VI.

In the average school system from .7 to 1% of stutterers are found. Most of the cases of stuttering recorded were very mild. There were only a half dozen severe cases of stuttering found in the whole 6,500 children. As there was no increase in the cases of stuttering, which is a neurosis, this tends to confirm the conclusion that there has been no increase in the neuroses among the children. The lisping cases were about one-half of the total. Only about half of these had defective occlusion. The remainder were either neurotic lispers or negligent lispers. Many of these cases, as well as the cases of indistinct speech, were due to malnutrition, which caused a condition of weakness and lack of nervous energy in the child, preventing the correct formation of coordinations necessary for good speech. The cases of thick speech were found chiefly among the feebleminded. Only two cases of uncorrected cleft palate were found.

Only the usual five per cent of the children were found to have definite speech defects. But it was noticed that the number of children who had slurring, poor, indistinct and lisping speech was astonishing. In some classrooms containing fifty to seventy-five children from six to ten years practically every one in the entire room was found to have a mild defect of speech—usually a slight lisp or indistinct speech. This cannot be accounted for by the language. The German language does not contain lisping sounds. Part of this almost universal condition of poor, lisping speech was due, we believe, to the influence of malnutrition upon the developing speech coordinations.

The speech survey showed: First, that there was no increase in the number of definite speech defects found in children who lived under normal conditions. Second, that the majority of the children suffered from poor speech or mild defects of speech such as lisping or indistinct speech, indicating that speech development was being, in a mild degree, delayed and interfered with. This condition was worst in first and second grades. The cause of this delay and interference was the malnutrition which was found to exist in more than half the children.

The facts brought out by the survey as recorded on the charts show only the children actually retarded or abnormal. But there were many children who—due to relaxed standards—were not retarded and who did not appear to the teacher to be definitely abnormal and yet showed quite definite changes due to malnutrition. To discover just what these changes were, the teachers were questioned, the children were observed in their classrooms, on the playground and in their homes, parents were interviewed, and a selected group of children were given special psychological tests.

INTERVIEWS WITH TEACHERS AND REKTORS

All the *Rektors* of the fifteen *Volksschulen* and more than fifty out of the 128 teachers were questioned as to what changes had been noted in the school work and behavior of the children during the war. The questions were not leading questions. The following form was used: "Have you noticed any changes in the behavior of the children, their energy, or their ability to master their school work since the war?" It was insisted that the answers be specific. If a teacher said his children did not learn so well or grew tired more quickly he was asked to give specific examples. Only when he was able to do this was his evidence considered.

There were several points upon which practically all the teachers agreed. They were as follows:

1. Children lack energy and grow tired more quickly than during pre-war days.
2. Grow inattentive after a short time.
3. Comprehension is much slower.
4. Memory is much poorer than before the war.
5. Children are more restless and discipline is harder to maintain.

Some of these points are not exclusive, poor memory depending on inattention, and slowness of comprehension depending partly also on inattention; but the points are recorded just as they were given by the teachers. We wished to record the changes not from a strictly psychological standpoint but from the practical viewpoint of how these changes appeared to the teachers.

1. Energy Changes

A lack of energy is not noticeable on the playground during a recess of ten to fifteen minutes. The children run, scream, dance just like perfectly well, normal children. One teacher said that the children, lacking the chances to play at home and the excursions to the country which they had in pre-war days, played during recess with a wilder and more enthusiastic energy. Before the war the teachers used to take the children of eight to fourteen to the playgrounds just outside the city for an afternoon's play.

So great now were the energy changes in the children that the play time had to be reduced and the violent running games had to be discontinued. It was found that the three-mile hikes, which used to be borne well by all, now so fatigued the children that they had to be discontinued. Last summer most of the children were not taken for a swim in the Moselle because many were so weak it was feared they might drown.

In the classroom most of the children are quite bright for the first period but they soon grow tired, begin to nod, and some actually fall asleep. I have seen on several occasions children fast asleep in the classroom. From observing these children in their classes one gets the impression of languor and lassitude. This condition affects about half the class. From ten to fifteen per cent seem weak, as though convalescing from a long illness. Although not feebleminded they are as immobile as though they were, sitting quietly in the seats in a dreamy state of weakness. Concerning this lack of energy in the classrooms it must be said that part of this may have been due to the ventilation, which in most schools is very bad. In some rooms the air was in a terrible state and the rooms overheated. The teachers claimed that the amount of coal for heating was so small that they could not open the windows and let in the cold air. They also claimed that the children were so thinly clad that the rooms had to be kept at a high temperature. It was clear, however, that much better ventilation could have been had if the teachers had so desired. Some schools were excellent in this regard.

From interviews with the teachers and from our observations of the children in the schoolroom, on the playground and in their homes we conclude that here in Trier from one-half to one-third of the children are lacking in physical endurance. They cannot run or walk far without becoming fatigued, they tend to become sleepy, and require more sleep than normal children. For mental tasks this lack of energy is even more apparent; this shows in an inability to concentrate, and in what may be called a lowering of the psychological tension necessary for adequate thinking. It may be simply put as a lack of physical or nervous energy. It is exactly similar to the condition found in individuals convalescing from a long illness. The changes are just what we should expect to find in children suffering from a lack of food. The degree of the lowering of the muscular energy necessary to perform physical tasks seems in most cases directly proportionate to the degree of malnutrition. The changes in the nervous energy necessary for mental effort, however, are proportionate not only to the degree of malnutrition but depend as well upon the excellency of the nervous stock of the individual. Children from good families show an extraordinary resistance to the effects of malnutrition. Though they may be in very poor physical condition their essential mental faculties are unimpaired and if tested for short periods when they are fresh they rate as children of good or superior intelligence. Some of the most typical of these cases will be discussed in detail, as well as the permanency of the changes noted.

That about one-half of the children are lacking in nervous energy and normal physical endurance may seem strange to the casual observer who sees the children on the streets skating, running, screaming and giggling, apparently like those in an average American city. It may be noticed that many have red cheeks and seem well nourished,—these are the children of the better classes seen chiefly in the parks and on the better streets. In the schoolroom a casual observer might form the impression that the children were as bright, alert and energetic as could be expected. To the layman malnutrition usually means a condition of actual starvation. The picture that presents itself *to him* is usually one of those emaciated infants seen in the magazines from time to time showing the famine sufferers in India. Malnutrition rarely goes so far, the individual usually dying from an infectious disease before an extreme condition of emaciation is reached. Observations carefully made and over a period of some weeks cannot fail to show the energy changes mentioned; casual observations cannot be trusted to give the correct impression in this matter.

2. *Inattention*

Unfortunately, schools everywhere are so dull that inattention is a feature found in all of them. But the condition found here is more accentuated than that usually found. The inattention is found to be greatest in the upper classes. That is, the children of six, seven, and eight years of age come nearer to showing the degree of attention normal for their age than the children of nine to fourteen years. The attention of the younger children can be held to some degree by constant urging, by frequent recess periods and by changing the work. But even these devices do not suffice to keep the attention of the older children. One teacher speaking of the first three grades says that before the war he could keep the attention of his class for a whole period of thirty minutes; now he cannot hold their attention more than five minutes. After a few minutes they begin to talk, laugh, wriggle about and there is nothing to do but to change the subject. During the afternoon session, 2–3.30, the attention of the children is so poor that no serious work such as teaching arithmetic can be attempted with children from six to ten years of age. There are some classes in schools situated in the better parts of town where the teachers say that they can hold the attention of the children as well as before the war but it takes very much more effort. In classes where there are children from the poorer sections the inattention is often extreme. After the first hour in the morning many of these children fall into a dreamy state of reverie and it is almost impossible to rouse them for new tasks. Even fairy stories would not gain the attention of more than three-fourths of the class. There was hardly one teacher who did not give "lack of attention" as one of the chief changes occurring in the children during the war. But only part of this inattention is due to malnutrition; part is due to the general war conditions.

3. Poor Memory

As would be expected the inattention causes poor memory. One teacher taught his class of sixty children aged ten a prayer of four lines. This was memorized. The next day only about five children could repeat this prayer. Before the war such was not the case. Another teacher told his class the history of four of the famous Roman ruins in Trier. Three days later only three or four children could repeat what they had been taught. Another teacher stated it used to take about fifteen minutes for his class of nine-year old children to memorize a prayer of five lines. Now it takes more than thirty minutes. Arithmetic seemed one thing that the children could not remember. The conservation and reproduction phases of the memory act seem unimpaired but due to the inattention which is so universal it is much harder and takes much longer to get the impressions recorded. When the interest and attention of the children were aroused there seemed no defect of memory.

4. Comprehension

The children are "slow of comprehension," this is the term used by the teachers to describe one of the changes noticed in the children since the war. Quickness of comprehension depends chiefly upon the facility of the associations. When there is a lack of nervous energy due to either weariness, illness or malnutrition it is to be expected that the associations would be less facile.

Following are some of the examples given by teachers showing slowness of comprehension. "It takes the children longer to think. When a question is asked a prompt response is obtained from only ten per cent of the class, the remainder of the class are very slow." "The class is not able to follow and comprehend the explanation of problems, specially arithmetical problems." "The teachers now have to tell their classes various facts and conclusions connected with their studies instead of, as formerly, stimulating the children to reason things out inductively for themselves." In short, the children appear stupid; they do not catch on quickly. One result of this slowness of the comprehension is that the lessons have had to be shortened. The *Rektors* almost all agreed that their teachers could only get through about three-fourths as much material in a given time as in pre-war days. Moreover, the subjects cannot be gone into with such detail. In history classes, for example, many subjects are merely touched on in a general way while before the war all the details, such as dates, exact boundary changes, names, dates and results of battles, were taught. Only part of this condition is due, we believe, to poor comprehension growing out of malnutrition. Part is due to other conditions growing out of the war—lack of home study, frequent absences and the general unrest.

5. Restlessness and Misbehavior

Children in the first, second, and third grades who are only six, seven and eight years old should not be subjected to a rigid discipline requiring them to sit still for several hours during the day, and to abstain from talking. But such is the requirement in most American and German schools, the only difference being that discipline in the German school is much more rigid. The young children are given recess periods at least once an hour, it is true, but during the study period they are expected to keep still and quiet. Before the war it was possible to maintain this rigid standard. But during the course of the war it has been noticed that the children have been growing more restless. They cannot sit still ten minutes or so with hands clasped on the desks in front of them as they are expected to do. They talk and giggle and whisper. This nervous irritability is quite noticeable. It is also noticed that some twenty per cent of the classes are too quiet and immobile. These are the dull and border line cases whose mental deficiency has been accentuated by the malnutrition. This immobility is quite marked. Such a condition is much more serious than the unquiet restlessness. But since these children give the teacher no trouble they are not noticed.

Much of the unquiet restlessness is due to the nervous irritability caused by the malnutrition and also by actual hunger. During the latter days of the week the bread was likely to grow short in the poor families; in some cases it actually gave out. From two to five per cent of the children in the poorer schools during the later days of the week came to school actually without any breakfast at all. In the autumn of 1916 the teachers said a larger percentage of children than this came to school without having any breakfast. Of course hungry children are restless and unquiet.

How this condition could have been remedied and how it was remedied by other German cities will be shown when the conditions found in schools of Cologne and Bonn are discussed.

The German teachers emphasized the lack of discipline found among the children. But aside from the nervous restlessness mentioned no real tendency towards insubordination or misbehavior was found. The children were really as docile as even a German could desire. This docility of the children suffering from malnutrition and even hunger is very interesting. Hungry men become anarchists and revolutionists, so it is said. It seems, however, that German school children under the age of 14 suffering from the same conditions have no tendencies in this direction.

In this connection it may be said that in general a certain rigidity and a spirit of harshness were noticed throughout the schools. The German teachers and *Rektors* were uniformly courteous and helpful; they did many things to help which they were not forced to do. Many of them gave up a whole day of the spring vacation to help. For these reasons we specially wish to be fair and just and to make no prejudiced statements concerning the schools. Many of the teachers were sympathetic and kind to the pupils. But in general we feel justified in saying that there was present a spirit of harshness. For example, it was difficult to keep most of the teachers from telling the child's family history in the child's hearing. Again and again teachers would tell of the immorality of mother or father or say that the family was stupid—with the child standing by. Children were criticised—called stupid or mean or bad—before the whole class. The fact that a girl had lice and nits in her hair and that her parents were lazy was often fully and freely discussed before the child and the whole class. When the teachers were requested not to do this, they often replied, "Oh, it doesn't matter," or "The children do not care." Sometimes the children were so embarrassed or hurt that they wept but no tenderness was ever shown them. It is not believed that these teachers wished to be cruel; but they seemed to lack the imagination to realize how very unkind they were; and it seemed to be the opinion even among teachers who were sympathetic and kind that rigid discipline and subordination to authority were quite the thing.

It was our conclusion that as a rule the German children lacked imagination; the small number of the neuroses tends to confirm this view. Sensitive, imaginative children would certainly show a considerable number of speech defects, such as stuttering, and neuroses if subjected to the rigid and rather harsh discipline which we found common in the *Volksschulen*. The children are crammed with information but little or no allowance is made for individual differences. The children recite in a loud, stilted manner, rising from their seats and speaking in a parrot-like fashion; some of the teachers make the children almost bellow when they read or recite. Asked why they did this the teachers replied that it forced the children to make the different sounds of the language correctly. Many of the teachers are old army sergeants and bring into the schoolroom the spirit of the parade ground. In some of the upper classes of boys, when a visitor enters, the children rise, their feet hitting the floor loudly and simultaneously, the whole sounding like a well-drilled platoon grounding arms on an armory floor.

In conclusion it may be said that the war conditions which have been mentioned had something to do with the inattention and restlessness, perhaps the slowness of comprehension, but the chief cause was malnutrition.

CHANGES IN DISTRIBUTION OF INTELLIGENCE

It would be expected that the mental changes in the children just mentioned, the growing inattention, restlessness and lack of ability to comprehend quickly, would have a general lowering effect upon the whole standard of school work. Such was the case. It is very hard to express this change in any definite way. Perhaps it can be done best through the following chart in which the distribution of intelligence among American children—as marked out by Professor Terman—is compared with the distribution of intelligence which was found here among German children.

Professor Terman found that one may expect to find on the average among American children that twenty per cent will have inferior intelligence, none of whom have an intelligence quotient above ninety. The lowest one to two per cent of this twenty per cent may be rated as feebleminded, having an intelligence quotient about seventy or below; sixty per cent will be found to have average intelligence, having intelligence quotients ranging from 90 to 110; and twenty per cent will have superior intelligence with an intelligence quotient of 110 or above; the upper one-half to one per cent of this twenty per cent may be rated as "near" genius or genius.

The distribution of intelligence was explained to the teachers, and the following question asked, "How many children in your class do work comparable to that done by the upper twenty per cent in pre-war days?" The highest number which any teacher gave was ten per cent. One very intelligent teacher said that before the war her class was recognized as one of the best in the school system, composed of children of officials. She has had the same class four years—now in sixth grade—and she has seen the changes take place. Now only four children out of forty-five are doing the class of work done before the war by the upper half of the class. On investigation it was found that these four children all came from families that were well-to-do, and so were able to buy their children a great deal of extra food. The teachers were agreed that probably less than ten per cent of the children were doing the class of work showing superior intelligence. Ten per cent then of the children of superior intelligence had dropped down to the level of those of average intelligence.

Then the question was asked, "How many children are doing work done before the war by the lowest twenty per cent of the children?" Some gave the number as high as fifty per cent, none less than thirty per cent. All the teachers who had taught before and through the war were separately asked these questions and their answers tabulated. It seems a fair assumption to take the lowest figure as indicating the true conditions. This would

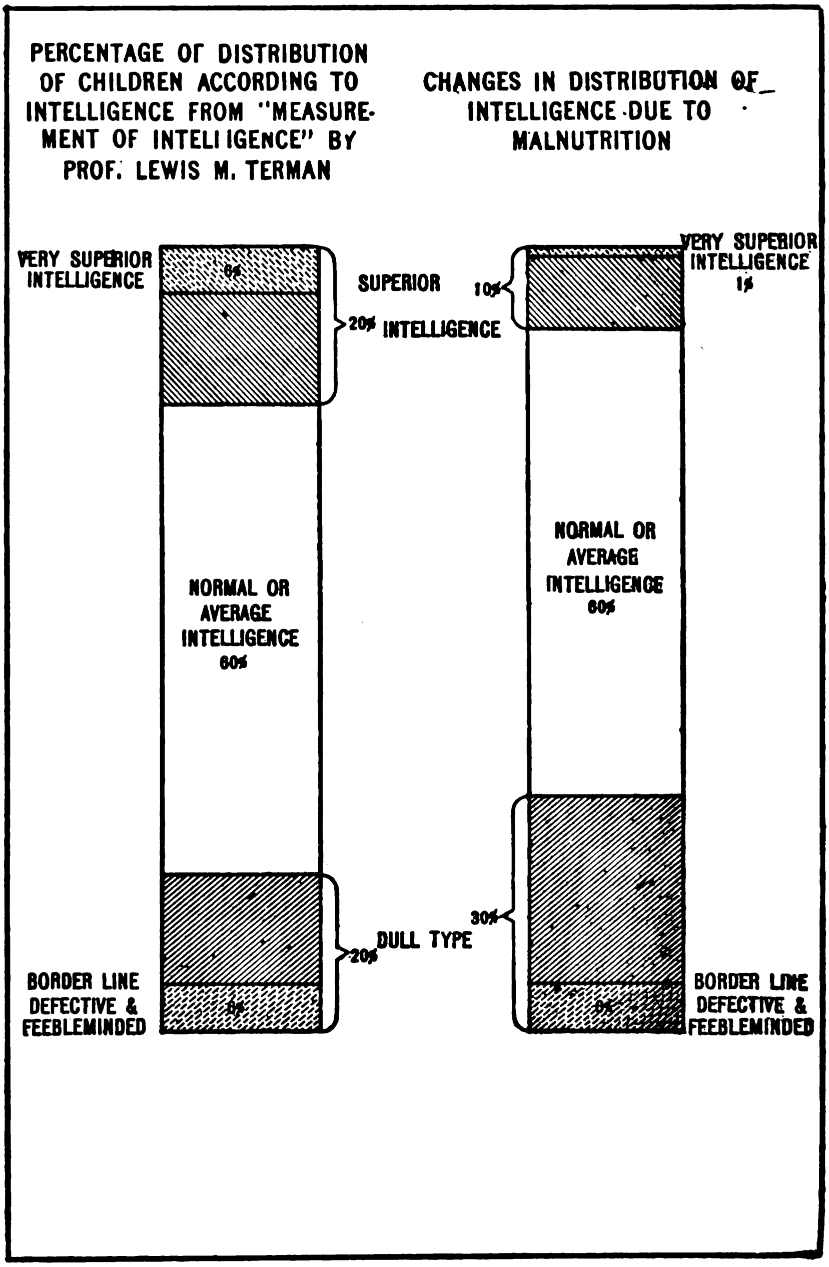

PERCENTAGE OF DISTRIBUTION OF CHILDREN ACCORDING TO INTELLIGENCE FROM "MEASUREMENT OF INTELLIGENCE" BY PROF. LEWIS M. TERMAN
CHANGES IN DISTRIBUTION OF INTELLIGENCE DUE TO MALNUTRITION
VERY SUPERIOR INTELLIGENCE
6%
SUPERIOR
20% INTELLIGENCE
10%
VERY SUPERIOR INTELLIGENCE 1%
NORMAL OR AVERAGE INTELLIGENCE 60%
NORMAL OR AVERAGE INTELLIGENCE 60%
30%
DULL TYPE
20%
BORDER LINE DEFECTIVE & FEEBLEMINDED
6%
6%
BORDER LINE DEFECTIVE & FEEBLEMINDED

CHART VII.

make full allowance for exaggeration. Taking thirty per cent as the correct number, it means that the lowest ten per cent of those who normally rate as having average intelligence now rate as having inferior intelligence.

The whole level of the school work has been lowered. Even those rated as having superior intelligence, except in exceptional instances, do not do as good work as in pre-war days. The question arises, are these changes in the character of the school work due to real changes in the intelligence of the children? An attempt was made to answer this question by selecting children suffering primarily from malnutrition and giving each a psychological test. The details of these tests will be given. It was found that those children who used to do superior work and now do average or poor work had suffered little or no impairment in intelligence. Their school work dropped off because they did not have the nervous energy to keep going all during the day. But the mental abilities of these same children in the morning, while they were fresh, were apparently as good as ever. In the afternoon, when tired or lacking in nervous energy, they did poorly and even appeared stupid. Certain children who came from families of superior intelligence but who were doing average or even poor work were tested—these too were found, in most cases, to have the intelligence level to be expected from the mental status of their parents.

Quite different results were found on testing those who had dropped down into the dull class, the lowest twenty per cent. These children were found to have an intelligence level corresponding to their school work. There were no flashes of intelligence, no special ability in the morning, but just a dead level of stupidity. The changes in the children of superior intelligence were only apparent changes; there were only a few exceptions to this statement; the intelligence level remained about the same. But the changes in the lowest ten per cent of those of average intelligence—the "near dull"—was a real change.

SPECIAL GROUPS TESTED

In order to discover just what specific mental and emotional changes are caused by malnutrition, two groups of children suffering from malnutrition in a marked degree were selected for special examination by means of psychological tests. Very little reliable data are to be had concerning such changes because most of the studies have been made upon adults, and any radical change in the dietary of adults arouses such an emotional reaction that it is impossible to determine the effects of the malnutrition *per se*.

The children we examined here under twelve to fourteen years showed little or no emotional reaction to the poor and insufficient food. They did not worry about the matter, or spend time dreaming of good meals, or analyze themselves to see what physical changes had occurred, how weak they were, how lacking in resistance to disease, how much weight they had lost or failed to gain. In these children the pure effects of malnutrition, unmodified by an emotional reaction, were obtained.

A nurse visited the homes of the children to be examined, and obtained a complete family and personal history. The living conditions found in each home, the family income, and the amount and kind of food obtained beside the official ration were recorded. Thirty children were selected for the first group who, from their history and general behavior, and the mental status of their parents and brothers and sisters, were supposed to have an intelligence quotient of 100 or above, but whose school work was average, poor or very poor. Ten children were selected for the second group who were supposed to have an intelligence quotient of ninety or above, thus rating as children of average intelligence, but whose school work was so poor that they seemed to be border line defectives or actually feebleminded. Cases were selected in whose family and personal history there was nothing to account for the poor work or actual retardation except malnutrition.

PSYCHOLOGICAL TESTS USED

The Terman Revision of the Binet-Simon scale was used. As a control several normal children not suffering from malnutrition were tested and they all rated according to their chronological age, showing that the scale was adapted to these German children. The scale was supplemented by an association test, consisting of a standardized set of fifty simple words implying opposites, as "black," "good," etc., which was given orally to each child who was asked to give as quickly as possible the opposite word, as "white," "bad," etc. The time necessary to give these opposites was noted by a stop watch. In this way the quickness of the associations was ascertained. The average reaction time of a bright child of about ten years of age for each word is not over two or three seconds. Learning ability was tested by counting the times a list of ten simple, unrelated words had to be read aloud for the child to memorize them so that he could repeat them correctly in the order given. The average bright child required only five repetitions. The tests were given through the German teacher who acted as interpreter during the survey and who was familiar with the use of the Binet-Simon scale. The children were all tested in the morning when they were fresh, and as they had all been seen several times, the fear of being examined by a strange officer was eliminated.

RESULTS

The following results were obtained from Group 1: Twenty-three children rated as having average intelligence, with intelligence quotients between 90 and 110; three rated as having superior intelligence with quotients above 110; and four as having inferior intelligence with quotients between eighty and ninety. All the cases with the exception of four showed a higher degree of intelligence than that indicated by their standard of school work. Twenty-six of the thirty showed the degree of intelligence to be expected from their family status and personal history, indicating that there had been no deterioration in intelligence due to malnutrition. The four found to have inferior intelligence were in very poor physical condition. Malnutrition if severe enough will finally of course affect the integrity of even a good nervous system. In these cases there was a definite lowering of the normal intelligence level; part of this change, we believe, will be permanent.

PERMANENCY OF MALNUTRITION CHANGES

A moderate degree of malnutrition in the feebleminded and the border line defectives and severer degrees in the dull and near-dull induce changes in the nervous system that will cause a more or less permanent lowering of the intelligence level. When such cases become well nourished they will improve, but will never be as intelligent as they would have been had they not suffered from malnutrition. We estimate there are not more than five per cent of the children here who have suffered permanent changes in their intelligence, and as these cases are practically all from the lowest levels of the population as regards intelligence these changes are not therefore so significant or important. Children who normally would have average or superior intelligence have undergone no permanent change, except in a few cases where the malnutrition has been very severe and long continued, and where it has been complicated by illness. These children of good nervous stock have been able to resist the effects of malnutrition, save for a few delicate ones who may have suffered a slight permanent lowering of the threshold of nervous irritability or may show a slight neurasthenic reaction throughout life. The only emotional change noted was a nervous irritability which was slight in most cases.

TWO TYPICAL CASES

First, a child of superior intelligence suffering from severe malnutrition and whose school work is very poor:

> Ernest P. Ten years and eight months old. Sixth grade. Five children in family. Father a painter, both parents quite intelligent. Mother does bead work at home for which she gets one-half mark an hour; the total family income is sixty-three marks a week. The family get one liter of milk a day from the city for the younger children. Their diet consists of ninety-five per cent rye bread, substitution coffee with a little sugar, and the usual turnip marmalade, potatoes, green vegetables, war soup and butter and meat on Sunday. About once a week the bread gives out and Ernest comes to school without any breakfast. The child is very thin and undersized, he has gained little or no weight during the last two years. He grows tired quickly and is evidently quite weak. Never had a serious illness but during the last year has not been well, frequent "colds," coughs a great deal, specially at night. His teacher says: "The boy is very poor in his work, but occasionally he seems quite bright; sits and dreams in class; answers slowly; hesitates; he is lazy sometimes."

The boy made a very good impression, he answered promptly and was alert. At times there was a slight blocking of his speech which amounted to a mild stutter. He had a good vocabulary and spoke good German. He tested above his chronological age, obtaining an intelligence quotient above 110. His memory span was good, comprehension excellent, learning ability excellent, association very good, vocabulary good. He gave over sixty words in three minutes. During the test lasting over forty minutes the boy was mentally on his toes; he was very tense. Toward the latter part of the test he grew restless, wrung his hands, rubbed his face, sighed frequently. His voice sounded tired and rose to a high pitch, almost a falsetto. It was clear that he was making a great effort. It was astonishing how well the boy did despite his very poor nutrition and his evident fatigue. He is a splendid example of the resistive powers of a good nervous system to the effects of even a severe grade of malnutrition. Of course he did poor work in school. He did not have the nervous energy to go through the day's work. It was little wonder that he sat and dreamed or that he appeared "lazy" to his teacher.

The sister of this boy, Maria, aged seven years ten months, was tested and had a mental age of eight years and four months.

She was very poorly nourished and did poor work in school though she had never failed.

Second case: Child who should have good average intelligence but because of severe malnutrition has undergone a lowering of the intelligence level and now rates as having only inferior intelligence.

Maria H. Aged eleven years, four months. Fifth grade, retarded one year. Father is a minor court official, both mother and father intelligent. Four younger and three elder children, all of whom are intelligent. The father gets only 225 marks a month, and the family have to get part of their food from the war kitchen. They get very little extra food beside the official ration and the food from the war kitchen. The family diet is the same as given in the last case, ninety-five per cent rye bread, coffee, marmalade, potatoes, war soup, butter and meat once a week. Maria is very nervous, the air raids frightened her extremely. She still dreams about them. She has gained no weight during the past two years. Often has diarrhœa and indigestion from the poor food, occasionally vomits. She is very poorly nourished, emaciated, pale, weak with slow, tired movements as though convalescing from a long illness.

The child tried hard during the test, but did very poorly. Her responses were very slow and she had to be urged to answer. She would sit for several minutes staring, apparently too tired to think. Attention wandered; voice sounded very tired. Associations very slow, several seconds longer than the average, memory span for only five numbers—the normal is seven—comprehension poor, learning ability and memory poor. After ten words had been read aloud to her five times she could only repeat five of them. Most of the children memorized all ten after five repetitions. She gave only twenty-eight words in sixty minutes but most of them difficult and unusual words for a child,—as "phlegmatic," "reason," "hardheaded," etc. She was found to have a mental age of nine years. Probably this child has suffered some permanent injury and will never be as intelligent as she would have been had there been no malnutrition. It is to be noted that this child suffered from indigestion—caused by the poor food—which accentuated the degree of malnutrition.

To summarize the specific mental and emotional changes caused by malnutrition: Children of superior and good average intelligence can withstand malnutrition even of a severe degree extending over at least two years with practically no impairment of the intelligence. They show, however, a lack of physical and nervous energy which results in poor school work and affects general behavior so that these children often appear stupid. An accentuation of emotional tendencies and a nervous irritability typical of neurasthenia are the only emotional changes noted. If the malnutrition is severe enough to overcome the astonishing resistive powers of these children of good stock there occurs a general lowering of the intelligence level. Malnutrition of such a severe degree usually leaves some permanent damage. In the case of children of inferior intelligence malnutrition causes a general lowering of the normal intelligence level. The changes being greater, the malnutrition being the same, the poorer the nervous stock. There is found a marked immobility and a lack of emotion; the same lack of physical and nervous energy occurs. The resistive power of these children is so poor that the nervous system is injured, and some degree of the changes noted are permanent. Not more than five per cent of the children seen here have suffered permanent changes in the intelligence and most of these are from the class of "inferior intelligence."

CONDITIONS IN TRIER NOT TYPICAL

It was desired to see if conditions here in Trier were typical of those throughout the Rhenish Provinces. We were told that Trier was one of the best fed cities in Germany and that conditions elsewhere, especially in large industrial centers like Cologne, were much worse. Three days were spent visiting the *Volksschulen* in the poorest districts of Cologne. More than 3000 children were seen. It was indeed surprising to find there such a small percentage suffering from malnutrition, scarcely twenty per cent, while in Trier it is estimated there are forty to fifty per cent.

The teachers complained of inattention and fatigability among the children but these conditions were not so marked as they were in Trier, and there was not the same lowering of the whole standard of the school work. The percentage of those failing to pass was not increased by the war. Only a few children out of 1,000 children seen in Bonn were found to be suffering from malnutrition. The *Schulrat* stated that the standard of the school work had not been materially changed by the war, and that most of the small number of children suffering from malnutrition were those who normally would be weak and sickly.

Some 1,000 children were seen in Coblenz and about the same conditions found as in Cologne. The better conditions found in Cologne, Bonn and Coblenz is accounted for by two reasons: First, there were large munition factories in these cities, the workmen received very high wages and could buy extra food, which was often unlawfully obtained by the factory owners and sold at cost to the workers. These workers had to be kept contented, so the government did not interfere. And second, excellent measures were taken by the city governments to prevent malnutrition among the school children. These measures were the same in the three cities but the work was done most thoroughly in Cologne.

In Cologne breakfast or dinner was given free to every child unable to procure these meals at home. In the year 1918, out of 90,000 children, 19,000 breakfasts and 2,500 dinners were served daily. Second, children in poor physical condition were sent to the country from one to three months and boarded with farmer peasants where they got good food. Most of this expense was borne by the city. In 1918, 9,000 children were sent to the country at a cost to the city of over 500,000 marks. Third, a limited number of children in very poor condition were sent to the "Forest School" at the edge of the city where they were well fed and stayed the whole day out-of-doors.

The results accomplished by Cologne and the other cities in preventing the spread of malnutrition among the school children would seem to indicate the conditions in Trier could have been much improved had the same measures been vigorously carried out. The lack of energy of the school authorities of Trier is shown by the fact that out of 2,415 children 896 were found to have head lice or nits, the excuse being given that the parents could not get any soap or vinegar or kerosene. In Cologne this problem was met by establishing a delousing plant in one of the city bath houses and lousy children, together with their families, were sent there and deloused.

It may be said that conditions in Trier are not typical; that the extent and degree of malnutrition and accompanying mental and nervous changes are greater, judging by the conditions found in Cologne, Bonn and Coblenz, than are to be found in general throughout the Rhenish Province.

CONCLUSIONS

The chief conclusions and findings of the whole study may be briefly summarized as follows:

1. At least forty per cent of the children in the *Volksschulen* of Trier, Germany, are suffering from malnutrition to such a degree as to cause a loss of nervous energy.

2. There has been no increase in the percentage of cases normally found of neuroses, psychoses, abnormal "nervousness," organic nervous diseases, tics or conduct disorders.

3. There has been an increase of the number of border line defectives totaling not more than one per cent of the total school population.

4. There has been no increase in the percentage of speech defects, especially stuttering, normally found; but there has been a marked increase in poor, lisping, slurring speech due to the retardation or interference of the fine coordinations necessary for good speech, caused chiefly by malnutrition.

5. The percentage of children failing to pass their grades has increased from an average of eight per cent in pre-war years to fifteen per cent in 1917 and 1918. It is estimated about half of this seven per cent increase in retardation has been due to malnutrition, the other half has been due to war conditions.

6. There has been a lowering of the whole standard of school work caused chiefly by malnutrition but partly by war conditions in general; half of the children who in pre-war times did superior work now do average work, and the percentage of children who do inferior work has been increased from twenty to more than thirty per cent.

7. The specific changes noted in the children caused by malnutrition are:

   (a) A lack of nervous and physical energy
   (b) Inattention during school hours
   (c) Poor and slow comprehension for school tasks
   (d) Poor memory for school work
   (e) A general nervous restlessness while in school.

8. Children of good nervous stock of superior or good average intelligence can withstand malnutrition of even a serious degree extending over more than two years without any impairment of the intelligence or any definite emotional change; a lack of nervous energy is about all the change that occurs. Children of poor nervous stock with poor or inferior intelligence suffer a general and sometimes a permanent lowering of the whole intelligence level from even a moderate degree of malnutrition. But not more than five per cent of the total school population have suffered injury to the nervous system such as to affect the intelligence permanently.

9. Conditions in Trier are not typical, being worse than those in general throughout the Rhenish Province as judged from the conditions found in the cities of Cologne, Coblenz and Bonn.

SUCCESS AND FAILURE AS CONDITIONS OF MENTAL HEALTH*

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THE idea prevails among educated people that the hygiene of the mind, or mental hygiene, is concerned with those who have no minds or who have defective minds, especially the feeble-minded. The idea that those who have normal minds, as well as the mindless, need the aid of mental hygiene, seems to be a very difficult one for most people to grasp. Perhaps this is because hygiene deals with such simple matters.

The essentials of physical health are the most common things of daily life,—fresh air, good food, exercise, sleep. The ordinary person thinks little of such things; but when digestion and other functions begin to go wrong, he desires something concrete and objective,—drugs, medicine, a trip to the seashore, or what not. In like manner mental hygiene has to do with very simple matters. But when an individual feels the need of help for any nervous or mental disorder, one expects, like the ancient Assyrian warrior, some great thing, something spectacular,—electricity, hydrotherapy, a rest cure, psychoanalysis, or the like. For the prevention of mental disorder, however, and the development of healthful habits of mental activity, very simple things are the essential things,—orderly association, healthful interests, normal attitudes toward life, attention to the present situation, a proper balance between stimulation and response, between work and rest.

One of these simple conditions of mental health, largely neglected, probably because it is so commonplace and so familiar to everybody, is success. In the healthful development of the child and in the efficient activity of the mature individual, this, and to a limited extent, failure also, are health conditions of fundamental importance. Please note for a moment the psychology of it.

The stimulus of success affects the child in the cradle. The infant wrapped in his blanket impelled by the fundamental impulse of activity, twists and wriggles and squirms, and when perchance he frees himself from the bands that fetter him, he exults in a debauch of motor activity. This is one of the great epochs in human development, when the child from his own activity achieves perhaps for the first time a marked success. If, after the manner of the great cartoonist, Briggs, we try to imagine what the baby thinks about in his cradle, we may naturally suppose that whether in conscious thought, or more naturally in feeling, the baby here realizes the satisfaction which comes from an end accomplished. From this initial success all through the wonderful achievements of learning to walk, and to talk, and the various motor accomplishments of ordinary life, the same stimulus of success is continuously active; and without it in large measure, arrest of development would occur.

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In its simplest terms success means the association of reality with a mental image. Take the case of a child opening and shutting a box. As perhaps everybody has observed, a child delights in doing a thing of that kind. Preyer's child opened and shut the lid of a box some 30 times. Here the child has a mental image of the closing lid and every time he shuts the box he gets the satisfaction of matching that mental image with reality; and it is such a delightful experience that he does it over and over again. This in its simplest terms is success. Later on we set up some end, either of serious work or of sport, some end to be accomplished; and when we accomplish it, we get success, whether it be in sending a tennis ball over a net or the result of a long series of events bringing about something of vital importance in our own careers.

The essential psychology of success is the same, whether we study the baby in his cradle, or the artist in his studio, namely, the matching of a mental image with reality. The mental state is often complicated by the zest of the activity, by feelings of power, and the like; but the essential psychological factor is this matching of the image with reality, or, if you prefer, the objectification and realization of a mental aim or end.

It is a great day in the life of a boy or girl when the first conscious effort for a definite end is distinctly made. Many a person can recall the time when first it dawned upon consciousness that a definite success in a certain line of work was possible. Many of you can recall the day when you first realized that you really could do some school task, or the like, distinctly well. The stimulus of it made you work perhaps as you never had before.

From continued success through many years an attitude of confidence is developed. On this largely morale depends, and in many cases a single marked success goes far to produce it. This stimulus of success is an essential condition of normal development and mental health. Continued failure, on the other hand, is liable to develop an unsocial attitude, the shut-in personality, and to plant the seeds perhaps of mental disorder.

Now, some one may exclaim, is that mental hygiene? We knew all that before. Of course we knew it before; but in spite of that knowledge we have built up a system of schools and developed methods of teaching and discipline that ignore it and make failure inevitable.

Let us note the conditions in the school from which come very largely the failures with which social workers have to deal. The entrance upon school life is a great crisis in the child's life. It is as great an event for the child, perhaps, as entrance into the army is for the new recruit. It is often harder for the child than entrance upon camp life is for the soldier. The entrance upon school life represents the great mobilization of all the child-forces of the nation; and some of us are trying to show that it offers a great opportunity for hygiene, both physical and mental.

The child from infancy has been matching motor images with reality over and over again and achieving remarkable success in motor development, and has also been achieving social success in many ways; then he is put in an environment where success is very doubtful, and many children, instead of achieving success, for quite a time experience the humiliation of failure. For many children in the school there is little opportunity for success. Failure in certain lines of effort is desirable; but failure in every thing is disastrous. Among school conditions and practices that tend to produce failure are the following:

(1) Without examination all the children of the chronological age of six, the developed and the undeveloped, the sick and the well, the feebleminded and the normal, the defective and the sound, are received into the school. As a result the teachers are handicapped, many pupils are given work for which they are not fitted, either physically or mentally, and a large percentage of retardation and failure is insured from the outset.

(2) The devotion of teachers to the subjects they teach as the thing of prime importance, often means the inevitable neglect of the object of instruction, the boys and girls to be taught. This tendency to consider first of all the subject and content of culture and to put the object of culture in a secondary place is found

everywhere. Mr. Cook, the author of the new book called *The Play Way*, puts this forcibly in the following passage:

"When will schoolmasters realize that, because of their iniquitous preoccupation with their 'subjects,' more than nine-tenths of the growth of a boy's experience is going on without any influence from them? When will they realize that a boy is somehow, or anyhow, adjusting himself with life quite apart from all their school-teaching? Because of their lack of sympathy and contact with a boy's real interests he is all the time out of their reach. Let any schoolmaster honestly consider which boys he is influencing, and he will find them to be those whose interests he shares, those in whose confidence he is, and these will not necessarily be the boys who are any good in his 'subject.' . . . A master's educational influence often has very little to do with the subject-matter of this teaching, and sometimes none whatever."

(3) Again the school minimizes the opportunities for success by the large heterogeneous groups organized into classes. In a large class it is almost inevitable that the teacher should be handicapped and forced to give attention chiefly to the dull and delinquent pupils, or to those especially bright, or to divide attention in a loose and inefficient manner over the whole group in a futile attempt to do justice to all.

(4) The school does not differentiate properly for exceptional children. Unusual children, and strangely enough those that are specially bright, often prove failures in the school or are retarded. Dr. Terman has specially emphasized the fact that the bright are often retarded; and, as everybody knows, the children interested in doing rather than in books often prove failures.

Not long since I visited a famous school and one of the teachers discussed with me the case of a boy who was unusual. He did not fit into the scholastic grooves and hence made an undue amount of trouble. The hope was expressed that he might outgrow his peculiarities; and the case of another pupil was cited who likewise had failed to drop into the lock-step but who a year or two later was satisfactorily lost in the crowd and gave no further trouble. Thus to the ordinary school a conventional failure is more desirable than a troublesome success.

(5) Most schools do not care properly for defective children. Among the pathetic tragedies of childhood are the cases of those who never can achieve success because of defect—the child with defective vision who cannot see the blackboard, the deaf child

who cannot hear the teacher, the child tormented with headache or toothache, the child whose brain nutrition is reduced by nasal obstructions, the sensitive child, the misunderstood child, and the whole list of nervous defectives.

(6) The prevalent custom of offering prizes for the best work in different subjects, and the like, gives the opportunity for two or three to succeed, but all the rest must necessarily fail. It would be far better to offer a reward for all who succeed in reaching a certain standard of excellence. Just as in some of the best summer camps, instead of a prize for the best, every boy who can swim a certain distance, or do a certain amount of work, receives a badge of honor.

(7) The fetich of symmetrical development causes many failures. A false pedagogy has exalted the value of an all round symmetrical training and of the advantage of doing what children are not well fitted to do, and in which they are bound to fail. How common this practice is everybody knows. An account of what would seem to be the earliest historic attempt at this method of training will be sufficient for illustration. I quote the report from a reliable scientist, the late Professor Dolbear:

"In antediluvian times, while the animal kingdom was being differentiated into swimmers, climbers, runners, and fliers, there was a school for the development of the animals.

"The theory of the school was that the best animals should be able to do one thing as well as another.

"If an animal had short legs and good wings, attention should be devoted to running, so as to even up the qualities as far as possible.

"So the duck was kept waddling instead of swimming. The pelican was kept wagging his short wings in the attempt to fly. The eagle was made to run, and allowed to fly only for recreation;

"All this in the name of education. Nature was not to be trusted for individuals should be symmetrically developed and similar, for their own welfare as well as for the welfare of the community.

"The animals that would not submit to such training, but persisted in developing the best gifts they had, were dishonored and humiliated in many ways. They were stigmatized as being narrow-minded and specialists, and special difficulties were placed in their way when they attempted to ignore the theory of education recognized in the school.

"No one was allowed to graduate from the school unless he could climb, swim, run, and fly at certain prescribed rates; so it happened that the time wasted by the duck in the attempt to run had so hindered him from swimming that his swimming muscles had atrophied, and so he was hardly able to swim at all; and in addition he had been scolded, punished and ill-treated in many ways so as to make his life a burden. He left school humiliated, and the ornithorhynchus could beat him both running and swimming. Indeed, the latter was awarded a prize in two departments.

"The eagle could make no headway in climbing to the top of a tree, and although he showed he could get there just the same, the performance was counted a demerit, since it had not been done in the prescribed way.

"An abnormal eel with large pectoral fins proved he could run, swim, climb trees, and fly a little. He was made valedictorian."

From this prehistoric attempt at ideal education down to the present many schools have put a premium upon failure. And from this continued effort to do work that cannot be done well, pupils are apt to acquire a slovenly attitude, and like the young horse given too heavy a load at first, they acquire the habit of lying down under a difficult task.

What can be more depressing than continuous failure in whatever one undertakes. As our classes are now arranged and school work ordered, it often happens that month after month many children have no legitimate opportunity to succeed. If a chance to leave school offers, naturally they take it.

In the American school, and even in many American homes, such artificial restrictions are often made that the most obvious opportunity for self-assertion by the children, and the most tempting opportunity for social success, consist in breaking the rules of the school or the exhortations of anxious parents. I have the report of one school where the boys made it a point of honor to break all the rules of the school each day, and they counted that day lost when they did not succeed. Such achievement by the boys of this school was a distinct social success, and of course it gave the boys the satisfaction that comes from success. But this does not give the highest form of moral and social training. The home and the school should at least give opportunity for success in legitimate activities.

This is merely one of the simple doctrines of hygiene often ignored. Perhaps it is not strange that many of the graduates of our schools have to be re-educated in hospitals or sanitariums. It is amazing how many adults would profit by such re-education. We find men and women in the sixth decade of life that have not acquired the habits of health that should have been formed in the first.

Again, application of the psychology of success takes the sting out of worry; worry may even become a condition of success, and when we face our worries and analyze them, that very activity may destroy the worry itself. This is the meaning of a recent editorial in the *Outlook* cleverly written in defense of worry.

The never-worriers, it maintains, can never reach the highest success. "Poor dullards of optimism, they miss the zest of that success granted to only those who have worried out a course of conduct to meet the most pessimistic forecast of the future."

"How can the poor optimist ever discover that one actually runs faster towards one's desire when the dogs of worry are nipping one's heels? Never the goal so alluring, never the pace so fleet, never the tingle of achievement so keen, as when one perceives the prize threatened. What does he know about success, the man who has never feared that he might fail?"

"But worry, to be genuinely educative, should be systematic and not slipshod. The worrier should have convictions to meet those of the good-cheer propagandist. But in this effort after analysis and argument your worrier must be mindful of one danger. . . . Method with melancholy inclines to have the same result as the proverbial tear-bottle offered to the crying child. In other words, worry is an elusive visitor; welcomed and analyzed, she is as likely as not to go flying out of the window."

All this suggests the right view of worry. Avoid worry if you can; and the knowledge of the serious physiological effects of worry helps one to avoid it, but it is futile to tell a child or an adult not to worry. One can, however, point out the things that can be done in a difficult situation; and the mature individual can face worry, analyze it, and mentally make worry itself an occasion of success. It is chronic worry that kills and not the brief and intense worry that soon ends in the grand and glorious feeling of success.

When we continuously fail in our attempts to match our mental images with reality, confusion of the mental images arises, or in other words chronic worry begins; and none perhaps are more prone to this than teachers and social workers. Their ideal is perfection. Naturally the great gulf between their ideals and their performance worries them.

Each individual must work out this problem for himself, but one rule is helpful to every one. Children should be trained and adult workers should train themselves to make their period of work one day, to live one day at a time,—what Dr. Osler has called "the freshest, the oldest, the usefullest" of all the hygienic rules of life.

No better rule for teachers and social workers could be devised. Each day has its failures and successes, but at the end of the day, however pressing the work, one should consider the book closed and the account settled whether for profit or for loss. Good as the rule is, perhaps you cannot adopt it. Children, can, however, in large degree be trained to it. Naturally they live in the present; they should be taught to live one day at a time, to settle their moral accounts every night, never to hold a grudge, never to let the sun go down upon their wrath, to look upon each morning as a new day in which to improve, but not to carry over their troubles from yesterday.

Of course in a world like this where failure is common and every day brings its disappointments as well as its successes, it may naturally be asked if mental hygiene has no words of encouragement for those who are defeated. The answer is that hygiene does have a message definite and positive for those who experience failure more than success. The help comes in the insight that after all the doing itself is the significant thing, that the fun is in the fight, and that the battle of life is worth making for its own sake. When one can make his goal effective doing without special regard to success or failure, then the doing itself from a psychological point of view becomes success; and thus we find strong men everywhere fighting losing battles, and the heroes of defeat are no less sane and healthful mentally than those who succeed as the world counts success. We find such men as President Harper on the one hand, who, stricken with an incurable disease, kept up his work to the last, and men like Jack London at the other extreme, who felt that even the gamble of life was worth while for its own sake. Thus he sings:

"This out of all will remain.
We have lived and have tossed.
So much of the game will be gain,
Though the gold of the dice has been lost."

Evil as this world is, it is nevertheless true that the doing, an active attitude toward difficulty, often justifies itself. Will you pardon me if I adapt a modern fable:

A large bottle of milk two-thirds full was left open one night in a farmer's shed. Two mice investigated the situation. By vigorous jumping they succeeded in gaining the top of the bottle and jumped in for the cream; then they were in danger of drowning. Mouse No. 1, had been trained by the modern method of constant failure and he cried out, "Help, Help," and when no help came, gradually lost strength and fell to the bottom. Mouse No. 2 had been trained by the constant stimulus of success and had become so habituated to facing difficult situations that he had even in a practical way gained the insight that doing is itself worth while for its own sake. So he cried out lustily, "Hustle, Hustle," and suiting the action to the word, kept trying to jump out of the bottle. At first he improved by practice and jumped higher and higher, but soon the effect of practice was overcome by fatigue, and gradually as he became exhausted, his jumps were lower and lower, but he nevertheless kept struggling; and gradually as exhaustion came on, the cream became harder and harder. In the morning mouse No. 1 was found dead at the bottom of the bottle, mouse No. 2 was serenely asleep on a lump of butter.

Keeping in mind the psychology of success, we see that anything whatever from the psychological point of view may be the occasion of success or failure. Since, in its simplest terms, success consists in matching a mental image with reality, it is obvious that this may be done legitimately and healthfully or illegitimately and pathologically.

The pathology of success is really a very large subject. It concerns, not merely the overstimulation that comes from continued success without normal relaxation, but the extreme self-consciousness of success that occurs often in the case of bright children of unstable nervous organization where it develops into ego complexes, and finally, perhaps, into megalomania. The pathological tendencies are seen also in very different and very simple and commonplace manifestations.

Some people never can think of doing a thing and be satisfied without doing it. If they think of saying a thing they must say it regardless of consequences. If one of a group refers to a familiar quotation they must repeat the quotation in full. If they start to do a thing they must finish it. If they see merely a pin on the floor, or a piece of paper, that suggests the image of taking it up, and however pressing their work may be, this mental image must be matched by reality, and before anything else they stop and pick up the paper and pin, or what not. Everybody knows how if one thinks of some trivial act like shutting a door or putting a chair in its proper place, one never feels quite satisfied until the thing is done. And some people in trying to recall a forgotten word, are in continuous misery until they can remember it. Of course such lower habits of success may interfere with the development of higher ones.

Most tragic of all perhaps is the fact that the stimulus of success is intoxicating, and is likely to make one heady. Hence is needed the antitoxin of failure. In the early stages this is a valuable remedy for the ego complex and a preventive perhaps of many cases of megalomania. Especially is this indicated at that stage of adolescent development when even the normal youth is likely to know it all; but this is an antitoxin that should not be given in too large doses.

I have not time, however, to speak of the stimulus of failure, nor of the moral aspects of success, nor of the physiological conditions of success and failure. Metabolism is clearly affected. Probably the glands with internal secretion are involved. Success is sthenic, probably increasing the flow of adrenalin, as a wholesome stimulus to function and a prophylactic to fatigue, toning up the whole system. Failure, on the other hand, is inhibitory and depresses function; and the inhibition of the will likely to result, unless one fights against it, may irradiate and depress all the activities, especially in the case of children.

The need of success as a wholesome stimulus is universal. Children have an enormous appetite for it. They need large doses. Adults become depressed without it. It is vital for the normal. The diseased are often cured by it. The modern method in the best hospitals of giving the patient as far as possible interesting work, something worth while to do, has demonstrated its value for health. It is the gravest error for physicians, social workers and teachers not to employ this wholesome stimulus.

The teacher's business is to see to it that every child at some time, in some way, in some subject, achieves a marked success, and that sometimes they get an honest gauge of themselves by failure. In like manner the task for the physician in large part is to give the patient the opportunity to do something that seems worth while, a definite concrete task to perform, either in caring for his own health, or in doing something that indirectly will be a benefit to health. The business of the social worker also in large part is to give concrete tasks to those who are chronic failures, to give the opportunity for success so that the stimulus of success may be a help to further activities.

Many of you have to deal with social failures, with the people who are down and on the verge of being out. Your problem, however, is much like that of the teacher and physician, it is the problem of giving each case something to do that is worth while, and of placing each individual in a situation where success is likely to occur; and when we recall the essential psychology of success we find that this is possible in many forms of work, and that the psychological success in doing ordinary work properly in itself is a stimulus to further work, and often the most important condition of mental health. In this sense every worker can give himself the benefit of this wonderful tonic.

Now all this is very simple, so commonplace that some cannot see its significance, but each of you can recall what a stimulus to effort success was in your own childhood; you know how the success of yesterday still warms your heart. The fact that you can do well certain things that are worth while gives zest to your life. You know cases where marked success in something or other has irradiated and affected the whole life of a child stimulating his will and ambition. You know cases of those in financial or domestic or social crises on the verge of nervous or mental breakdown where a marked success has been their redemption.

Thus on such simple things, to the ordinary person simple, to the psychologist often complex, our mental health depends. By such simple conditions our habits, our association complexes, our characters are developed. On such simple conditions sanity and insanity depend. Of such simple things mental hygiene consists.

EDUCATION AND MENTAL HYGIENE*

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THE proof of the pudding is in the eating of it, and so the test of an education would seem to be how it actually works out, how successful are the men and women so educated. Opinions, however, differ as to what constitutes success; is it a bank account, church standing, scientific reputation or personal happiness? Smith, prosperous in business, rolling along in his automobile, thinks rather pityingly of poor Jones, an impractical sort of fellow, who writes scientific articles, but can never afford a trip to Europe or to join a decent golf club. Jones, on the other hand, elated by the discovery of a new insect, which will probably be called by his name, in his spare moments thinks with some pity of the failure of Smith, who started life with some decent enthusiasms, some responsiveness to the finer issues of life, some capacity of self-sacrifice, but gradually lost them as he became immersed in piling up a fortune. Brown, who has neither discovered a new insect nor accumulated any money, but whose family life is a great delight to him, sees nothing but failure in the life of Smith and of Jones, neither of whom can get along with his wife.

There is no universally accepted standard of success in life; one is forced to admit different goals and therefore different methods of education, and each one will favor that type and those methods which fit in with his philosophy of life or personal prejudices.

The physician tends to look at the matter biologically; his goal in education is the adult well adjusted to his environment, with healthy organs but also with a healthy balance between the conflicting trends of human nature; an adult not merely well nourished and with immaculate teeth and tonsils, but meeting the tasks of life with the necessary output of energy and with pertinacity, not shirking from or evading personal problems, not giving to the realities of life false values, determined by individual idiosyncrasies, by earlier experiences, by uncorrected family or social prejudices; handing over to habit the simpler activities of daily life, regulating soberly the instincts, digesting disappointments and bereavements, giving and taking in the spirit of social solidarity, facing the tests of marriage and parenthood, in a direct and open manner, throwing himself into his economic tasks with cheerfulness and satisfaction.

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In the formative period the child should of course acquire a certain amount of information, and skill in intellectual and manual operations; both the nature and extent of the information, and the best methods of tuition are important topics of discussion. But the breakdowns in life—the nervous invalidism, embitterment and depression, misinterpretation and accusation, ill-balanced enthusiasms and fads of religious, philanthropic, intellectual or aesthetic nature, family disharmonies, futile daydreaming—do not arise because the individual has studied Homer and Euclid instead of Spanish and the stock-exchange reports, or because he has followed the methods of the kindergarden instead of expressing his individuality in a Montessori atmosphere. The failures are more influenced by the fact that in the developing individual less attention is paid to the personal problems of the child than to the accumulation of information, less attention to the instincts, the emotions, the interests, the mental conflicts than to memorizing and facile repetition; yet during this period habits of adaptation are formed which are to be of crucial importance for the happiness and efficiency of the adult.

The state, which realizes the importance of literacy sufficiently to make education compulsory, not leaving it to the personal decision of parents, pays little attention in its educational apparatus to the training of character. It is easy to arrange for the systematic instruction of large groups of children in arithmetic, language, geography, history, etc. It is another matter to arrange for systematic help to groups in regard to more important factors that are going to be of fundamental importance for the happiness and the social value of the individual. Perhaps such training can never be quite systematic; perhaps the training can never be by group methods; for it is no longer the giving of information that is in question, but training in feeling and doing. While the importance of this aspect of the training of the child can hardly be doubted, the question may be raised whether this part of the training of the child does not belong essentially to the home, while the function of the school is different. Of course, the school should not aim at supplanting the home; no external influences are of more importance for the formation of character than the atmosphere of the home; thus the training during the first five years of life has an influence of profound significance on later character. But while the school should not supplant the home, it should supplement the home; it should cooperate with the home, and bring to the home an influence and a support which no other agency can supply. Along with the parents the teacher should aim at the development of the character of the child, the formation of correct habits of thought and action, the regulation of the instincts and the emotions, the cultivation of a sensitiveness to the true values of life.

But even should the school desire to split the child into two halves, handing one over to the parents for character-training while it retained the other half for instruction, it would still not have shaken off the wider problem. The child brings its whole self into the schoolroom, its emotions and interests and special personal attitudes, and even the routine task of instruction is modified by these factors. Learning is modified by the attitude of the child to teacher and to schoolmates, and this attitude is a factor of great complexity, to understand which we may need to know something of the home and of the attitude to the parents; interest in the school tasks may be seriously interfered with by daydreaming, and the roots of this may introduce us to the sexual life of the child and his inner life of phantasy; failure in the school tasks may be conditioned by sensitiveness and embarrassment and nervous fear, the origin of which can only be revealed by a detailed character study; lack of docility and restlessness in the schoolroom, with a tendency to pranks and lack of seriousness, require to be understood if they are to be dealt with intelligently; teasing and bullying and apparent cruelty require investigation; pilfering and untruthfulness, truancy and apparently wanton mischief are other examples of conduct which call for careful study of the individual child, and an honest endeavor to provide the child with the conditions most favorable for its development.

The school, therefore, cannot disclaim responsibility for some attention to the personal problems of the individual child; compulsory attendance laws show how important the state considers education for the maintenance and advance of the value of its citizen body, and if the human value of its citizens is to be the main aim of the school system, then not only will these personal problems of special school children receive careful attention, but the chief weight of education will come gradually to be laid on this aspect of the training in general rather than on routine instruction in the familiar school topics. The value of any school system will be estimated according to its success in promoting the development of character and habits and healthy balance.

Already the school has gone a certain distance in this direction; it has seen that to treat a child as a mere numbered school unit, morally bound to swallow at a certain rate a certain amount of information, is a grave injustice. It has been seen that a child with an empty stomach cannot absorb much grammar or arithmetic; to add the figures on the blackboard one needs to see the blackboard; a slight deafness may be the cause of much fatigue and irritability. The school, therefore, has taken an interest in the empty or abused stomach, the defective eyes and ears, the diseased teeth and tonsils, the infected skin.

The school having thus accepted some responsibility for attention to stomach, teeth, tonsils, etc., must accept some responsibility for the child who owns these organs, for the real child, not the mere school unit. The real child is not merely an assemblage of organs plus a receptacle for school information, he is a complex bundle of highly organized instincts, emotions, and attitudes; and attention to these reactions of the child is even more important than attention to his teeth. These are the elements which give to the individual much of his special character and worth; their management is of cardinal importance for the training of character, while at the same time they intimately affect the progress of instruction. The close relationship between the traditional problems of the school and the wider and more important problems involved in the personality of the child and his total reaction to his environment may be illustrated by a concrete case.

John Smith, aged thirteen, was a problem to his teacher and a nuisance; his honesty was not beyond question, he frequently lied, his pranks however amusing were distinctly unsettling in the schoolroom. Four teachers formulated their views of this upsetting school unit.

The English teacher reported: "His efforts to keep up in his work have been so very irregular that I cannot explain it on the ground of mere laziness or indifference. He does not know the meaning of application and, while not mentally deficient, seems quite unable, in certain moods, to retain the fundamentals of previous study. If this is due to shiftlessness, as I think it to be in part, I suggest a severe reprimand." The history teacher reported: "John Smith has very good ability. His poor work is the result of loafing and lack of interest including attention in class. He is quite an enigma." The mathematics teacher reported: "I know of no reason why John Smith's work should not be good. . . . Frequently does no work during the week, that is, hands none in, and yet passes fair tests. Of course, continuance of such work means gradual loss of grip and consequent failure." The Latin teacher reported: "My impression of John Smith is that he has plenty of ability, but very little energy. He very rarely hands in his written work on time and usually does about half of it."

From these reports one sees that John Smith is an unsatisfactory pupil and to one teacher "quite an enigma." But what is striking about these school reports is that there in no reference to the boy himself, his real interests, his attitude toward life, his instincts, his ambitions, his affections, his fears. Although the school career of the boy was threatening to prove a failure no attempt seems to have been made to look outside of the schoolroom for any explanation. We find mentioned "lack of interest," "inattention," "very little energy," "no application"; but these stereotyped phrases teach us nothing; we want to know the why of the matter, what is going wrong with the boy, what are the driving forces in his nature, and how they can be applied to advantage. In these reports we see no reference to the home, no curiosity as to the boy's relations to his parents, his personal feeling for his masters, as to his output of energy away from school, as to his special tastes, sex life, possible feelings of discouragement, and their source. The teacher of algebra sees no reason why the boy's work should not be good, but the English teacher confided that "he just hates algebra"; surely some reason for poor progress.

If the teachers had considered John Smith not as a pupil, the victim of a school curriculum, but as a live boy, who had once been a baby, had been brought up by a mother and a father, they would have developed a healthy curiosity as to the why of his failure. They would have regretted that the early life of the boy was not at their disposal, that the whole balance of the unconscious forces, the direction of his affections, the trend of his ruminations, his mental conflicts and methods of meeting personal difficulties, in fact the very essence of the boy was quite unknown. They would have wondered whether the boy's output of energy was not handicapped by emotional factors, the source of which might be elsewhere than in the school. As a matter of fact the boy was frank and free at games and showed a quite energetic disposition when he was carefully observed in holiday conditions. He was observed to have a somewhat diffident attitude as if he were not quite sure of himself and felt that he was liable to be criticized or viewed with disapproval. He seemed to be weighed down by the feeling that he was not quite up to the task before him, whether it was a Latin exercise or diving. He responded well to encouragement which inspired him with confidence in himself.

The boy seemed to be living under the chronic weight of the feeling that he was not quite up to the task before him. The atmosphere of the home might well explain this attitude; we know how important an early determinant of character is the child's relation to his parents. The boy tends to live up to the father and where the father has modest ideals of efficiency and a fairly easy-going tolerance, the task does not weigh on the child. In this case the father was a man of exceptional ability with very high standards of efficiency; to live up to such a father may be a stimulus or an incubus and the patient, with more modest endowments than his father, which were poorly utilized in his early school training, had labored under the sense of lagging behind what was expected of him. This chronic feeling of discouragement had probably been the most important single determinant of his general waywardness, don't-care attitude, and unsatisfactory school career. On the basis of this tentative reconstruction of the boy's difficulties he was given an atmosphere of encouragement; a policy of tolerant watchful waiting was recommended, with moderate demands as to school attainments and no attempt to force progress at the risk of discouragement; the father and teachers cooperated in supplying the boy with the conditions which his special problems seemed to demand, and the results justified the effort.

The above history may show how even in relation to instruction and school discipline the problems of the home and of the school are intimately connected, how the emotional background of the child's life subtly influences school progress, how the familiar annoyances and disappointments of the classroom may require for their understanding a detailed analysis of the personality of the boy and of all the factors which make up his environment. One is entitled to demand of the teaching profession in general some familiarity with these problems; in every training school for teachers there should be a thorough course in child psychology, a psychology willing to deal with the real problems of the child, and that faces the realities of life in a frank and unembarrassed manner. No such course would be complete without some personal contact with children, who have presented the typical difficulties of adjustment, and whose cases have been thoroughly analysed.

Such a programme does not mean an additional burden to teachers, it means a new stimulus and inspiration; it brings a fresh human note into an atmosphere that at times tends to become somewhat musty; it opens up a vista of productive work in mental hygiene, which might well tempt the very ablest men and women to enter the teaching profession. Even the harassed and underpaid teachers of many a second-rate school system may find in the intense human interest of these problems a satisfaction which is some compensation for their hardships. The importance of the cooperation between school and home has been indicated in discussing the case of the boy. The present almost absolute divorce between these two is pernicious; the parents and teacher have the same youngster to train and cooperation is not possible without frequent consultation. The teacher with his technical experience can be of invaluable aid to the parent, the parent can bring to the teacher data as to the home reactions of the boy, his heredity, his past experiences, without which the boy might remain an enigma. How many school children remain mere stuffed enigmata!

The example I have chosen for discussion presented in the foreground difficulties as regards instruction. Teachers, however, meet in addition large numbers of children presenting problems of the most varied nature. It is not necessary to mention the familiar problems of children with a greater or less degree of mental defect, whether the defect be intellectual or in the sphere of moral response or stability of motor output; that is a problem to which justice is being done.

In addition to these backward children the teacher meets children who pilfer, or have St. Vitus dance, or lie, or stammer, or play truant, or are hysterical, or who are bashful or depressed or afraid or seclusive, or who write obscene notes or show other sex interests of unusual degree or nature, or who have peculiar habit-spasms, or who are unnaturally good and precise, or who complain of headache, or who play all sorts of unsuitable pranks. A child is lagging behind his grade; is it due to undernourishment, or to daydreaming, or is the child too bored by uninteresting information to make progress? The child plays truant; is it because of unappetizing school fare, or does the child constitutionally lack the appetite for information which his fellows have, and therefore wanders off, or has he superabundant energy with love of adventure, or is the truancy due to the influence of bad comrades, whose influence in other directions may be still more pernicious?

The child shows lack of response to discipline; is it due to a constitutional defect, or to faulty home training and home atmosphere, or is it due to emulation of "movie heroes," or is the personality of the teacher at fault, or is the defiance of the teacher the continuation of an antagonism to the earlier authority of the father?

Mere routine punishment in such a case may merely tend to fix the attitude, whereas it may take all the teacher's insight and sympathy to modify the boy's attitude so that he may develop into a helpful social unit instead of into a truculent and unwilling worker, defiant of all authority, a fomenter of discord, a nuisance to himself. The fact that a child memorizes easily is little indication of development; the fact that a child gives a teacher no trouble may merely indicate lack of initiative and character. We wish to know how the child tackles a job, what interest does he bring to it, how easily is he discouraged, what standards satisfy him, how far is he capable of teamwork, whether he is a generous rival or meanly envious, whether he cherishes grudges or squares accounts in a manly way, what are his special interests and aptitudes, what his habitual output of energy, how far his emotional life seems well balanced. In fact the main thing is what sort of a boy or girl have we to deal with, and in our estimate the stock of school information at his disposal should only have its due weight and no more.

If these views in general are accepted—and sooner or later I believe they will have to be accepted—and if an honest attempt is made to translate them into action, what are the first steps for a school system to take to live up to these responsibilities? Instead of sketching a utopian school system in a community guided by intelligence, let us assume an average school system run by average authorities with an average community with average taxpayers. We may safely assume that on a plea of economy they will continue to underpay the teachers, and that they will be far from offering salaries at all commensurate with the importance of the teacher's task. The classes will continue to be much too large on the same basis of economy. The teachers, therefore, are liable to continue for some time overworked and underpaid. If, however, in their training they have got some insight into the fundamental problems of childhood and some familiarity with the indications of trouble, they will be sensitive to the indications of such trouble in the children who are daily under their eyes, they will be able to draw the attention of the principal of the school to the need of special observation and care of the individual child. The ideal situation would be for the teacher to have only a reasonable number of pupils in her class, and to have some energy and time at her disposal for discussing with the parent the home problems of the child, and for visiting the home if advisable. As the teacher seldom has the time or energy available, the problem may be referred to a visiting teacher or school nurse, who must have had some good training in mental hygiene and in the special problem of childhood. It will be long perhaps before the average teacher is qualified to give the best advice in relation to the problems that come up, but it should be possible within a few years to have available a body of these special intermediaries between the home and the school, whether they be visiting teachers or school nurses with special training in mental hygiene. One of her functions would be to be familiar with all the hospital dispensary facilities of the community. In this way there would be placed at the disposal of the child the best advice and treatment which the community could furnish, the teamwork involving the teacher, the visiting teacher or school nurse, the dispensary with its staff of physicians and social service workers. As to what one might suggest for a community sufficiently intelligent to consider the education of its children as its greatest responsibility and with the first claim upon its budget, it is perhaps as well to be silent; this conference is more profitably employed in the discussion of practical recommendations which should be driven home at the present time, than in formulating schemes complete but so remote of realization, that workers are apt to be discouraged.

It is quite stimulating to think that, even with an unprogressive school board and with meagre appropriations, the intelligent and sympathetic teacher can have such a beneficial influence on the life of her pupils; and nothing is more likely to help the progress of the school board, or to elicit the taxpayers' money than to give them a good concrete demonstration of what real education is.

So far I have discussed education chiefly in relation to the school period, but the education of the child has begun long before it goes to school. The education or training of the child begins when it is put to the mother's breast; the basis of the child's later reactions is being laid when the child is forming its habits with regard to food and sleep and the toilet; traits of character which are handicaps in later life may be fostered by injudicious management in the nursery; the basis of later repressions, of later inability to deal frankly with sex factors, is laid in repressions connected with the habits of the toilet, and with the first naïve curiosity of the child as to sex differences, childbirth, etc. These early reactions of the child are familiar to the nurse and the mother; only the child psychologist is blind to them, or if not blind to them considers them not suitable for discussion. Adult traits of character of the greatest importance are often determined by the emotional relations to father and mother which are established early in life; undue fostering of the emotional dependence of the child on the parent may do much to cripple the individual's social efficiency as an adult, and may make him find the world a harsh step-mother. The child who finds he can dominate his small world by tantrums and other technique, has to learn at a later day that the real world has certain inexorable laws, and may regret that the existence of these inexorable laws was not brought home to him in the nursery. The general ignorance of the principles of the correct training of children during this early period is a social fact of very great importance; it presents a situation which demands organized treatment. The most practical way to deal with it, it seems to me, is already suggested by our discussion of the relation between the school and the home. The school nurse or visiting teacher or social service worker, who has to take up the problem of a school child, has to deal not merely with a child, but has to deal with a situation; and to give the child the help it is entitled to, the situation has to be dealt with intelligently.

The nurse sensitive to the problems of the home cannot improve the situation for the school child without helping the mother in her general insight into the problems of childhood. She will inevitably have to consider the mother's attitude to the other children, will have to see along what lines she is molding their habits and character; the mother herself will be only too glad in the presence of the worker, who has a sympathetic insight, to bring up her problems with regard to the younger children, and to avail herself of wise counsel. So through the school-children the school workers will have an entrée into homes which will bring them into close contact with the children who are under school age, and in a community where the school is doing work of this nature, where some mothers have got help with regard to their 3-year-olds and 4-years-olds and 5-years-olds on questions of diet, and thumb sucking, and tantrums and night terrors, and other nervous manifestations, other mothers, whose children are all below school age, will come for help to the same source. Show some mothers that practical help is given; these mothers will look after the necessary propaganda, and the mothers of the children under five will soon be clamoring at the doors of the school clinic for help for their children. Can the school refuse their appeal and will it not have to answer it by seeing that the school clinic becomes the mental hygiene center for all the children of the district, no matter of how tender years the children may be?

When this situation is adequately organized, the community may at last feel that it has taken the education of its children seriously, and that it is giving to its children those aids to the development of personality and character, to which from infancy they are entitled.

SPECIAL PREPARATION OF THE PSYCHIATRIC SOCIAL WORKER*

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WERE it possible to define the psychiatric social worker more accurately than it is possible to define any other kind of social worker, one would find it less difficult to speak in specific terms about the special training for psychiatric social work. Unfortunately, this is not the case. Notwithstanding the extensive discussion and publicity which the subject has been receiving of late, we are still considerably in the dark concerning the precise nature of the services that the psychiatric social worker is expected to render.

Much obscurity still surrounds the question as to how these services differ, if at all, from those expected from any well trained social worker. Are we interested in producing a specialized kind of worker who is to confine herself exclusively to work with psychiatric cases, and if so, at what strategic point in the community is she to function? Is there any likelihood that this stressing of a specialized vocational field in social work might tend to restrict instruction in psychiatric principles of approach to those who intend to specialize in psychiatric social work, and if so, is it not highly important that this tendency should be counteracted?

Are we to interpret the current interest in the training for psychiatric social service merely as a response to a long-felt need on the part of the medical profession for a kind of extra-medical aid which might assist the physician in solving the mental, financial, industrial, social and domestic problems with which the medical problems are so closely enmeshed or are we to view this active interest on the part of social workers in the subject of psychiatry as a genuine, albeit belated, recognition on their part that psychiatry might aid them materially in the solution of the various problems of social maladjustment which call for their intervention?

If the latter is the case, is it not extremely important that we formulate the contribution which the psychiatrist might make to the field of social service in terms of a science of human behavior, rather than in terms of a restricted specialty which deals solely with pathological issues?

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I am far from agreeing with those who would see in all social work a reflection of psychiatric issues. At the same time, I am strongly of the opinion that the principles of mental hygiene, and the technique of dealing with human problems, which psychiatry has evolved, deserve a wide application in social case-work, even where no clear-cut psychiatric issue presents itself. I might further state at this point that, because of this, I am personally very much more interested in the psychiatric training of the social worker, and by this I mean a training which would give the student a helpful insight into the fundamentals underlying human action and conduct, normal and otherwise, than I am in the specialized training of a psychiatric social worker.

I need not say that this in no way signifies a lack of sympathy with the movement for training of psychiatric social workers. Every experienced psychiatrist has long recognized the need for this, and the School with which I am affiliated offers ample opportunity for such training.

But if I interpret correctly the aims of the Mental Hygiene Department of the New York School of Social Work, a department which has been put on an equal footing with the older, well established departments of the School, training for psychiatric social work is by no means its exclusive or major object. It is hoped that its influence will be felt not only in the vocational field of psychiatric social service, but in the various other specialized vocations for which the school is training. It would be difficult to argue one's self into a belief that the type of training which would equip the social worker to deal with those problems of maladjustment, which we call "psychiatric," would have less value in dealing with problems which arise in the fields of industry, family welfare, child welfare or criminology.

How training in the fundamentals underlying human conduct may affect, for instance, the thinking of a student whose chief interest is industry, was expressed by one such student in a recent examination paper. He says, "The course gives further grounds for the belief that every situation which arises in social case-work requires recognition, analysis and treatment based on the premise that each case is unique with many possible varying aspects which make it different essentially even from other situations bearing the same name.

"The knowing of the apparent and perhaps originating cause of the situation of maladjustment does not mean a knowing of the nature of the social problem which must be solved, for the social problem arises out of the individual's reaction to the occurrence rather than out of the occurrence itself, and this reaction is conditioned by the nature of the personality of the individual concerned.

"Unemployment, for instance, may react to produce widely different social dilemmas, or may react as a strengthening and invigorating agent according to the nature of the person into whose experience it comes. In one man it may be the causal factor of a line of worrying leading to a nervous condition or an apparent neurasthenia; in another it may be the agent for simply revealing to the social case-worker the fact of feeblemindedness; in another it may develop a moroseness which renders the individual incapable of using all his power to find and get another job; in another it may react to produce a careless and rebellious attitude which may become dangerous; in still another it may produce a situation in which poverty is the outstanding social problem involved. On the other hand, for the man who has become so settled and fixed in one line of mediocre routine work, an episode of unemployment may be the occasion for an awakening, a shaking-off of desuetude and an awaking of the personality to the effect of making it bold and self-assertive again."

It seems to me, psychiatry might well aim to contribute materially toward the shaping of the student's attitude of mind toward social problems in general. It might assist him in acquiring a correct estimation and interpretation of the subjective, personal factors involved in the various ill-adjusted relationships between the individual and the group which call for social service. It might assist him in gaining a fuller realization of the fundamental principle that no matter how impelling and significant external factors might be in the causation of these maladjustments, it is after all the effect which these external factors have upon the individual or group that must determine every step in the social worker's procedure. It ought to help him to understand better the difficulties and failures that are met with in social work through an emphasis of the need for an estimate of the capacity for response to the endeavors of the social worker on the part of his client and to recognize the nature and meaning of abnormalities in such responses when they occur.

It ought to bring to his attention the many facts which demonstrate clearly the causal relation between mental defect, abnormality or disease and social inadequacy, on the one hand, and on the other, the effect which adverse social-economic conditions might have upon the mental health and equilibrium of the individual.

It might point out to him the kind of soil upon which mental disorders tend to thrive, and stress the reasons for the frequent need in psychiatry of dealing with "situations," with "settings," rather than with symptoms or even disease entities.

These are some of the legitimate fields of endeavor of the psychiatrist in participating in the training of the social worker, and if he is to discharge this task adequately, he must indeed have a broad conception of psychiatry.

Unfortunately, and this is a fundamental difficulty in the psychiatric training of the social worker, formal psychiatric literature does not present the subject of psychiatry in a way that would meet these requirements. It naturally stresses medical aspects and leaves most that is of vital interest to the social worker to conjecture.

What interest, for instance, can the medically untrained student of social work have in the highly technical description of the pathology of organic diseases of the brain to which textbooks on psychiatry devote so much space, and is there not a grave danger of confusion in the promiscuous and undirected acquisition of a mass of technical phraseology through the reading of texts which were primarily prepared for medical students?

This difficulty is not obviated in any way through supplying the student with scores of references to existing literature, which I am sure even the average medical student would find only confusing, or through the marshalling of a most imposing array of lecturers for the benefit of the student of social work.

I doubt whether this will assist us materially in developing a dependable curriculum for the psychiatric training of the social worker.

And this, I take it, is the fundamental reason for bringing up this subject for discussion before this conference. The various questions which we have referred to seem to me to merit serious consideration before we plunge too deeply into this enterprise, else the genuine concern of some psychiatrists as to the dangers of undermining professional standards, or the flight into a kind of self-realization on the part of the social worker which has prompted at least one ambitious young man to apply to the Regents for a license to practice psychiatry, might become more disconcerting issues than they are at present.

The stressing of psychiatric training for social workers alongside of the specialized training for social service with psychiatric cases need not render more difficult the orderly presentation of the psychiatrists' contribution to the curriculum of the school for social work.

As a matter of fact, the steps in the training only begin to diverge when the candidate for psychiatric social service is called upon to practice in the actual doing of certain things which are peculiarly related to the practice of psychiatry. This divergence certainly should not be thought of before the student has acquired a substantial grounding in the theory and practice of social work, and in the fundamentals underlying human conduct.

The student begins to specialize in psychiatric social work when her field work or practice work begins to be in connection with psychiatric cases, and it is most important that this phase of her training should be just as much under the direction and supervision of the psychiatrist as is the classroom work.

Here one can speak in more specific terms of what we might attempt to train the student to do.

Having realized through the classroom work how important it is for psychiatric diagnosis and treatment to obtain a reliable picture of the setting from which the patient comes to the psychiatrist, the student should be given an opportunity to practice in the making of field investigations that might be of value in diagnosing a given situation.

She should be taught to estimate accurately the facts thus gathered in the light of their value for a helpful insight into the biologic, cultural, economic and social backgrounds of the patient. She should be made familiar with the type of approach needed in dealing with the mentally diseased or defective and their relatives, and this can only be acquired through close association with the work of the psychiatrist. She should be trained in the correct interpretation of the psychiatric findings in so far as they relate to the planning of steps in the rehabilitation and reconstruction of the patient. She should gain the ability to make the kind of intimate contact with the patient which alone assures the successful carrying over to him and to his associates of the principles of conduct and life which a given case calls for.

She should learn to estimate available community resources for the bringing into her patients' lives the interests and activities that might promise a fuller and happier existence. Similarly, she must familiarize herself with the industrial opportunities for the handicapped.

It goes without saying the opportunity ought to be given her to become acquainted with the common danger signs in the lives of the mentally disabled so that she may be able to feel her way with some degree of security in the emergent handling of these signs. I am still undecided to what extent the psychiatric social worker ought to be depended upon for the taking of life histories of patients. The temptation must be great for the psychiatrist to relegate this task to someone else, but the danger involved in turning a mentally ill patient over for an intimate searching into his life and difficulties to a lay person must not be overlooked. I am similarly in doubt about the relegating of mental testing to the social worker, though the danger here is not nearly as great as in the previous case.

Certainly, whatever is done in this connection should be done under the direct personal guidance of the physician and cannot be relegated to long distance supervision. I have also found it difficult to decide for myself to what extent the social worker should become a party to the intimate relation which must exist between the physician and patient. I feel, however, that this is a question that must be decided in connection with each case and that it will always depend very much upon the social worker one has to deal with. This is an important question for both the psychiatrist and the social worker, for while principles of mental hygiene and of psychiatric guidance may sound very attractive and plausible when presented as generalizations in the classroom, the situation assumes a different aspect when the two workers have to combine in the application of these principles to the concrete case.

This leads us naturally to a very important point with which the psychiatrist might well make it his business to acquaint the social worker:—namely, the limitations of psychiatry and of the psychiatrist, a point not very much stressed by my colleagues. It is bad mental hygiene not to acknowledge and face squarely these limitations and it renders unnecessarily difficult the close cooperation between the psychiatrist and the social worker.

But if it may not always be convenient for the social worker to supplant the psychiatrist in the taking of the life history of the patient, she should receive ample instruction in the meaning and significance of various events in the life of the individual and in the causal relation between certain events and mental disability. She should be made familiar with the dangers that lurk in an unintelligent relation between parent and child; in a faulty handling of the instinctive life of the individual; in an evasive attitude toward reality and an inadequate settling of daily problems as one goes along; in the cultivation of aspirations and ambitions which are markedly at variance with innate capacity. She should be alive to the capacity for evil which lies in the erroneous choice of one's vocation, in wrong mating, in a too exclusive reliance upon certain outlets. The power which certain events and experiences have in conditioning faulty attitudes of mind, prejudices, and hampering obsessions, the place of rationalization in the daily life of the individual and the unconscious motives in conditioning conduct are further outstanding features of the contribution which the psychiatrist might make to the training of the social worker, irrespective of what vocational field might claim her major interest.

In order to insure a fruitful soil for principles of mental hygiene in the mind of the student, she should be led up to an acquaintance with these principles through an orderly presentation of the structural and physiologic bases of conduct, not necessarily a minute study of the structure of the nervous system or a refined presentation of the physiology of the sense organs, which is sometimes called psychology.

We have in mind a discussion of the place of the nervous system in the evolution of the human organism, of the relative import of its various gross subdivisions, of the unit of structure and the unit of function in the nervous system, of its integrative function and the dependence of the organism upon this function for its security and well being. We would stress the mechanism of the reflex, particularly of the conditioned reflex and the reflection of this mechanism in the formation of mental attitudes and trends.

This ought to make easier the understanding of the instinctive components of conduct, a proper presentation of which ought to prepare the way for a discussion of the theory of the unconscious. The delineation of the mental mechanisms which the study of the unconscious has brought to light would naturally follow, and would make possible the presentation to the student of a kind of psychology which might be related to practical everyday affairs, and which might aid him in understanding the real motives in human conduct, and a knowledge of what men live by and for, of the respective interests of the individual and society, and of the numerous possibilities for conflict between these interests. In all of this presentation we must not forget that we are dealing with medically untrained people, and that textbooks prepared for the student of medicine are not wholly applicable for the social worker.

At this point one might profitably review some of the essential facts of biology, particularly stressing those which would give the student a sound and common sense view of the subjects of heredity and eugenics.

The danger of an unwarranted overenthusiasm in these directions must constantly be kept in mind, since the community has a right to expect of the social worker some guidance here, and the social worker should see in it a very worth while opportunity for the exercise of her function as a trained advocate of social betterment.

This should naturally lead us to a discussion of the development of the personality, and here it is my strong conviction we should accept the principle of psychic determinism and should give the deserved attention to the various other helpful and significant points which analytic psychology has brought to light. An open-minded attitude towards the analytic school of psychology will help materially to get away from the rigid, static concepts with which traditional psychiatry is still burdened when we come to the discussion of clear-cut pathological issues.

At this point the student should be given an opportunity of applying the classroom instruction to history taking and in the construction of a psycho-biological record of a case.

When we come to the consideration of pathological issues the available data should be so arranged as to stress particularly social aspects, and clinical phenomena should be presented as modes of biologic and psychologic reactions rather than as disease entities.

One might begin with a discussion of the reaction types of the group of socially inadequate, the feebleminded, the constitutionally inferior, the epileptic, and point out that in the main, the type of approach here is in the direction of a simplification of the environment.

Much opportunity presents itself in connection with a discussion of these inadequate personalities for stressing significant social-economic factors as related to the preventive, ameliorative and supervisory aspects of these conditions.

Furthermore, in no other field of mental pathology is it possible to demonstrate so clearly and so effectively the causal relation between abnormalities of mind and social maladjustment. The consideration of the constitutionally inferior and psychopathic personalities makes possible for the student a helpful realization of the borderland of psychiatry and an appreciation of the principle that there is no strict dividing line between mental soundness and diseases of the mind.

It should also prepare him to see in the make-up of the individual a determining element of the reaction type which he is likely to manifest.

There is no better place than at this point in the entire field of psychiatry for a discussion of the medico-social implications of such behavior manifestations as criminality, vagrancy, prostitution, alcohol and drug addiction and chronic pauperism.

The very extensive field of the functional mental disorders might best be introduced by a discussion of the psychoneurotic type of reaction as affording the best opportunity for a gradual transition from the normal to the abnormal and for the emphasis of the very helpful viewpoint that the difference between the benign and the malignant forms of mental disorder is after all largely a difference in the degree of dissociation of the personality and not so much a difference in kind.

Especially is such a view helpful for workers in this field who are primarily interested in therapy and not in classification.

If one might speak of the fundamental difficulty of the psychoneurotic as being essentially a disturbance in the unity of the personality, one need not conjure up a more complex or mystical explanation for the dementia praecox type of reaction.

The fundamental difficulty here which consists of a tendency to a withdrawal from reality may be traced, without much difficulty, back to faulty habits of adjustment which lead to a progressive loss of ability to meet the demands of real life.

As is the case in the psychoneurotic, so here too, the mental disorder is the result of more or less definite antecedent psychobiologic factors, and is just as purposeful.

It is not my intention in this paper to enter upon a discussion of the subject of psychiatry. What has been said was intended to illustrate a type of presentation which ought to prove particularly attractive and useful for the non-medical worker in this field, in as much as it demonstrates, as one of my students put it, "how normal, after all, the abnormal are," and that mental disorder is not something that springs upon an individual suddenly out of a clear sky, but is the outgrowth of more or less definite, traceable, antecedent phenomena.

Only such a view could make preventive work attractive to the social worker, and enable her to feel that much of what is possible in a therapeutic way with these patients demands very little more than a simple, direct, human way of approach at understanding the patient's difficulties and at assisting him to a more healthy and constructive way of handling his problems.

A similar approach is possible in the manic-depressive and paranoid types of reaction.

In each of these conditions much that is discussed in available textbooks might well be omitted as either too technical or as of not much interest to the social worker, and in its place substituted a fuller and more definite presentation of therapeutic methods and approaches at adjustment. One should also stress the point that the problems which arise in connection with disorders of personality, unlike those that go with other medical issues, are seldom if ever limited to the individual concerned but affect to a greater or lesser extent other members of the patient's family or have even a wider social bearing.

In connection with the presentation of the exogenous forms of mental disorder, particularly those due to alcohol and syphilis, an excellent opportunity is at hand for a discussion of the broader social aspects of these conditions, and these phases should be stressed even more than the strictly medical ones. For instance, in connection with paresis it is much more important for the social worker to know that there are more deaths of this disease in New York City than of typhoid fever; that it costs the state of New York about one-half million dollars, annually, to care for the insane whose conditions are due to syphilis; that this fatal disease, paresis, is due to an infection which is preventable; that only about 10% of the off-spring of syphilitics are absolutely well; etc., than it is to know what structural changes take place in the cells and blood vessels of the paretic's brain.

Similarly in connection with the discussion of the alcoholic disorders, it is of much less interest to the social worker to know the pathology of wet brain than it is to gain a helpful insight into the social aspects of alcoholism and, at the present time particularly, to have pointed out to her the possible problems with which she will have to cope as a result of national prohibition.

The treatment which the other organic disorders receive in textbooks on psychiatry certainly needs much revision for the social worker. Causes, symptoms, probable outcomes in mental disorders must be presented to the social worker in a manner that will demonstrate to her the many possibilities which psychiatry offers for the exercise of her function as a kind of individual therapeutist, on the one hand, and on the other, as a trained advocate of social betterment.

But no matter how complete and specialized the didactic instruction of the social worker in principles of mental hygiene and in psychiatry, the right goal will not have been reached unless this instruction is supplemented all along with discussion of actual case material. And by this I do not mean descriptive studies of psychiatric cases. This is of relatively little value for the social worker, as is walking through an insane asylum and looking at insane patients. I have in mind case material in which an opportunity presents itself for a demonstration of the detailed steps in procedure in the combined handling of a case by the psychiatrist and the social worker, and not merely case histories which recite the facts that have led to a psychiatric diagnosis. Such case material is not very abundant and can be developed only through the combined efforts of the psychiatrist and the social worker.

It may not be out of place in closing to say a few words concerning the plans of the Mental Hygiene Department of the New York School of Social Work.

Provision has been made for a course of lectures of 60 hours extending throughout the first year which is to be devoted to a psycho-biological consideration of human conduct and its disorders.

This course of lectures is available for all students of the school. Specialization in psychiatric social work will begin with the second semester of the first year, when the student will be given an opportunity to work with us at a psychiatric clinic and will devote all her field-work time to work with psychiatric cases.

The second year's work of the student in psychiatric social work will be almost entirely clinical under my personal direction and under the immediate supervision of a specially trained worker.

Through this combined psychiatric and social handling of the case, the student will have the opportunity of seeing as far as possible the whys and wherefores of each step in the procedure and will acquire through the actual doing such principles of mental hygiene as ought to be found helpful in the handling of ill-adjusted human relationship.

THE TRAINING OF THE PSYCHIATRIC SOCIAL WORKER*

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WHEN it was proposed last spring to train a group of social workers for the purpose of aiding in the reeducation and treatment of the soldiers who were suffering from the war neuroses and psychoses, there was anxiety felt regarding what was considered very much of an experiment. What should such a group of women be taught? How could they be made of the greatest use? If they were to help carry out the instructions of the psychiatrist intelligently, would it not be necessary for them to know much of the detail of the mental life of the patients? Would not this knowledge necessitate their delving into fields which are usually unfamiliar to the lay worker, and even to the medical worker? What would be the effect of dispensing such knowledge to young women, many of whom had only just finished college? Were they old enough to assimilate what has caused many an older person mental and emotional indigestion?

Although we wondered and feared, at the same time we also desired. It seemed such an opportunity, such a chance to jump ahead in our ideals of mental hygiene, such an opportunity to broaden the field of the social worker. Besides, there was an urgent demand for persons thus trained. The physicians from Canada told of the great need of specially trained social workers to help in the reconstruction of their soldiers who were suffering from mental and nervous disease. A neuro-psychiatric unit had already been mobilized in our own country, which included some of our best mental nurses. But there were few social workers who had had the special training which would equip them to do the social work that might be necessary.

In giving such special training, however, should we not be taking too great a risk in introducing to the theories and actualities of mental disease a group of young women who represented a variety

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of experience and training? In answering this, we had only to recall the pluck and endurance that had been shown by women of other countries in the midst of the most horrible situations, and to remember what some of our own countrywomen had already accomplished, to be convinced that even though the war was two thousand miles away, a group of our women, if wisely chosen, would be equal to any task for which they were needed.

Furthermore, there was the question whether it was wise to take a group of women without medical training into the sacred precincts of the temple of psychiatric thought, which not infrequently had been kept free from the, shall we say, profane presence of the mental nurse. Here again the need seemed to warrant the risk taken. The psychiatrists themselves would hardly be able to devote as much time as would be necessary for the reconstruction of each case. Some one would have to help in carrying out the details of the plans they would indicate. Should it not be a trained rather than an untrained person, and should not that training be the most fundamental possible?

What part of the field of psychiatry should such a group be taught? We had no intention of including the whole field and attempting to make psychiatrists of lay workers. The greatest emphasis should, we thought, be laid on the study of the principles of mental hygiene. Much time should be devoted to the interpretation of mental symptoms, considered in general as they occurred under the headings of different mental diseases, and in particular as they appeared in the war neuroses and psychoses. From the first, it was emphatically stated that our purpose was not to make diagnosticians of our students, but rather to cultivate in them a comprehending and sympathetic attitude toward the problems of mental disease. Therefore, a course was decided upon which should give to the students a knowledge of human behavior, both normal and abnormal, and should train them to be of practical use in the study and treatment of abnormal mental conditions.

Besides the course in psychiatry, there were courses in sociology and in psychology. Each of these from its own point of view aimed to show the struggles in the adjustment of elemental instincts which have been necessary as civilization has advanced from lower to higher levels. The course in sociology included lectures and conferences on case-work, and the practical problems of the adjustment of the individual to the community through the utilization of its many resources.

In addition to the lectures in psychology, a short course was given in mental testing, again not with the purpose of making diagnosticians, but of increasing the student's understanding of the significance of mental tests when performed by others. Some of the class who had had previous experience were given opportunity to test patients at the state hospital.

In order that the training given might be as intensive as possible and might represent the best work that has been done in the field of mental medicine, the cooperation of many of the leading psychiatrists of the country was asked. Vassar had already established a precedent in the plan of a course for the training of nurses. This plan which we were glad to follow far exceeded our expectations in the amount of continuity it was possible to maintain and in the intense interest which it aroused among the students. In the course in psychiatry alone, there were twenty-three visiting lecturers. Contrary to what might be expected, the subjects followed each other in as consecutive a manner as though they had been given by one lecturer alone, and what repetition there was, was said on the authority of the President of the College to be good pedagogy!

The course in social psychiatry was introduced by a lecture on mental diseases in general. It was thought desirable to consider then the mental conditions that have a definite physical basis. This naturally took us into the field of neuro-syphilis and the mental conditions that are caused by poisons and trauma.

Early in the course, the class studied history-taking in detail. Later on, there was required from each student a history based on this outline, which was to include a well worked out personality study. Each student was urged to take herself as a subject as it was supposed that in this way much data would be available. It was also felt that a knowledge of her own conflicts and adjustments would constitute one of the best preparations for her work with the conflicts of others.

Personality was studied in the greatest detail, first as seen in the normal individual, and then as it develops in the various abnormal mental types, in the disorders of delinquency, in the psycho-neuroses, in mental disease of alcoholic origin, in the manic-depressive psychoses, and in dementia praecox.

The class was extremely fortunate in having two weekly clinics at the Northampton State Hospital. This added greatly to the interest of the course and made it possible for the students to see the various types of mental disease they were studying. Besides this, lectures illustrated by lantern slides and a moving picture film added to the graphic presentation of the subject. Once a week, an evening lecture was given which the public was invited to attend.

Those who are familiar with the study of psychiatry know that there are different schools which deal with mental problems from quite opposite points of view. As it was probable that the different points of view would be represented in the various hospitals to which the students would be sent later on, it was thought advisable to present to them opposing opinions and theories even at the risk of causing some confusion. In order to eliminate, as far as possible, unnecessary and unproductive controversy, each lecturer was asked to state his point of view frankly in the interpretation of mental symptoms, and to omit all expression of opinion which would tend to prejudice his hearers against other points of view.

In looking back over the course, it seems impossible that the group should have been able to assimilate so much in so short a time. Each lecturer, however, spoke on the subject to which he had devoted much time and in which he was consequently greatly interested. His enthusiasm was contagious and the class responded with a corresponding amount of interest. They appreciated the opportunity of hearing men who had given years to the study of one subject, and faith in the judgment of these men enabled the students to utilize theories which, under other circumstances, it might have taken them years to accept. The four daily hours of lectures lengthened frequently into a much longer time because of the unflagging interest among the students and the lecturers. The additional four hours for daily reading, which supplemented the lecture hours,were conscientiously utilized.

The two months' course of didactic work at Smith College was followed by six months of practical work at various mental hospitals and clinics, where there was also opportunity for a continuation of psychiatric instruction. At the present time, the forty students who completed the course are holding positions of responsibility in this country and in Canada.

As a result of last summer's experiment, a permanent school is to be established at Smith College for social work in the following four branches: psychiatric social work, medical social work, child welfare, and community service. Furthermore, three other schools of a similar type have been started in Philadelphia, Chicago, and New York. If the interest in this type of training continues, it will be possible for every mental hospital and clinic in the country to be supplied with a psychiatric social worker.

Digressing a moment, let us consider life a series of adjustments, roughly classified as two-fold: first, the internal or the individual adjustment, and second, the external or the environmental adjustment. The rôle of the social worker is then to aid in the solution of the problems of maladjustments of both types. The task of the medical social worker, as we know it, consists first in aiding the physician to make the patient more fit physically (the patient's internal adjustment from a physical point of view), and second in utilizing the social and industrial resources of the community in helping the patient make his external or environmental adjustment. The task of the psychiatric social worker consists first in aiding the psychiatrist in making the patient more fit mentally and in developing his personality to the extent of his individual capacity (the patient's internal adjustment from a mental point of view), and second, in common with the medical social worker, in utilizing the resources of the community in helping him make his environmental adjustment.

It is this difference which calls for the difference in training. The healing of a lung from tuberculosis or the treatment of a heart that is not functioning properly requires detailed treatment, it is true, but of a very definite nature, which demands usually the following out of a physical procedure. On the other hand, the treatment of mental symptoms and the adjustment of cases exhibiting anti-social conduct require a knowledge of individual mental adaptability and development. The social worker who is to help carry out such treatment must be able to appreciate her patient's capacity for adaptability and assist the physician in helping the patient to make his individual as well as his environmental adjustment.

It is doubtless true that all of us, the mentally normal as well as the abnormal, are capable of greater powers of adjustment than we display; that with wise counsel followed by the process of mental and physical reeducation, we could all attain greater power and usefulness. The time will come, we believe, when a knowledge of human behavior and of the principles of mental hygiene will be required in the training of every social worker. The war has brought about the realization of the need of this knowledge for the social worker in the field of psychiatry. Before long there should be a realization of the importance of this training in the field of social work in general.

The dissemination of knowledge regarding the principles of mental hygiene may be accomplished in two ways: first, through the education of the mass by means of public lectures, literature, and educational procedure in general; second, through the intimate contact between individuals in the clinic and in the home. It is in the second type of work that the psychiatric social worker has an opportunity to spread in a community knowledge of the principles of mental hygiene.

In the past, there have been on the one hand our mental hospitals where the psychiatrists come in contact with the well marked cases of mental disease; on the other hand, there has been the community where social maladjustments and incipient mental disease come only too seldom to the knowledge of the psychiatrist. The social worker is the natural go-between. She visits the hospitals and she visits the homes in the community. If she is equipped with knowledge that will enable her to recognize social maladjustments which should be corrected and abnormal mental symptoms when they first develop, she can guide the patients to appropriate channels, while readjustment is possible and the prognosis favorable. She will thus have vast opportunities for supplying the much needed link between social maladjustments and mental disease, or in other words, between the community and the mental hospital.

To summarize what we believe to be the field of the psychiatric social worker, she will, through understanding of the true interpretation of mental symptoms, be able to spread in the community an attitude toward mental disease that will do much toward encouraging treatment in early stages. She will be able to carry out in detail and with intelligence the treatment which the psychiatrist indicates but which he does not have time to carry out, and she will be able to aid him in his study of each case by contributing a true picture of the patient's reactions in his different environments. Besides this, she will bring to the mental problems that confront the psychiatrist the help that a knowledge of the social and industrial resources of the community can contribute.

The psychiatric social worker is the outcome of a war emergency. What the field of war neuroses and psychoses might have evolved, and of what service these workers and others similarly trained might have been in work with our soldiers will perhaps never be known. Still a definite need for psychiatric workers (psychiatric aids they have been called) has already been recognized in the community. The opportunities of the future lie in applying their usefulness to the general field of mental hygiene. Since here the field is boundless, their opportunities will be unlimited. The degree of their success, however, will depend largely upon the opportunities given them by the psychiatrists and the community to prove their usefulness.

QUALIFICATIONS OF THE PSYCHIATRIC SOCIAL WORKER*

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THERE is nothing more difficult to make concrete and definite than the qualifications relative to age, intelligence, training, experience, personality, etc., that fit or unfit one for a particular vocation. That is why vocational guidance or vocational tests, except in the most general sense, are not wholly reliable and satisfactory. No sooner do you have one trait selected as necessary for a particular field than an exception is pointed out in the group already working successfully in that field. Human nature has such unaccountable ways of compensating for apparent handicaps that our predictions in any individual case may easily fail. Nevertheless, despite variation in individual cases, it ought to be possible, even with our relatively brief experience in the field of psychiatric social work, to arrive at some very general conclusions regarding those qualifications, personal and otherwise, which seem to point most definitely to the potentially successful psychiatric social worker.

Before we can go very far in describing the desirable candidate for psychiatric social work, we need to be sure that we agree on the kind of work that we expect her to do. Briefly, do we mean by psychiatric social work just ordinary social service which only happens to be directed toward the mentally ill, plus a background of familiarity with hospital organization, psychiatric terminology and mental symptoms, and a cleverness in guessing at the diagnosis of a case which is as superficial as it is irritating, or do we mean something fundamentally different, a new way of approaching all case-work which has evolved in the psychiatric field largely because any thoroughgoing attempt to deal with the definitely mental case required it?

In my experience, both types of social service are now to be found in the field of psychiatric social work. I am not interested in describing the qualifications of workers in the first group because I believe any experienced social worker, public health nurse, or medical social service worker is already sufficiently equipped and needs no further training. She can pick up the tricks of the trade very easily in the clinic or hospital. I do not wish to belittle this type of social service; I believe it has a place, but I see no reason to give it a special name because it happens to be attached to a hospital for the insane, or a clinic for mental and nervous diseases. My conception of the new case-work which perhaps has always been the unconscious method of the born case-worker, but which owes its coming to consciousness largely to mental hygiene and psychiatry, is that of a social technique such as may be secured in any good training school combined with an understanding of human psychology which enables the social worker to deal with the personality of the patient in his social setting as intelligently and constructively as the psychiatrist deals with it in the hospital.

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This does not imply a knowledge of mental disease in terms of diagnosis, symptoms or classification, but it does imply a first-hand, working psychology which will be able to carry out in social treatment the psychiatrist's interpretation of a patient so far as it can be done in terms of personality. Such a psychology will also give the worker her basis for dealing with the maladjusted individual who may be classified as normal and who is not a hospital or clinic case. All of which is simply one way of saying that in the last analysis the social worker who goes beneath the surface of practical, commonsense, social adjustments, and kindly human interest, must become a kind of working psychologist, not the laboratory research or clinical type, but something more human, vital and practical. Knowledge of social life is inadequate if it is not combined with knowledge of mental life. Back of the social framework is the make-up of the particular individual, his way of adjusting to people and things and the possibility of improving that adjustment. Real case-work, psychiatric or otherwise, cannot be done from the outside and the inside work requires the type of person, the experience and preparation which should be expected of one who, even as the psychiatrist, accepts responsibility for adjusting the mental and social life of other human beings.

Now, is there any reason why this kind of social psychology with individuals, as it might be called, should be so definitely linked with psychiatry? Cannot one deal with mental life without knowing all the symptoms of the various mental diseases? The reason it has been so linked is undoubtedly because in social service with the mentally diseased, the necessity for understanding the make-up of the individual has been forced upon us and because psychiatry has done so much to make psychology a practical tool for altering mental conditions. The reasons for continuing to keep it linked with psychiatry are that there is no way of obtaining so vital an understanding of normal behavior as by studying the abnormal and because thus far psychiatry has the only psychology which attempts to reach scientifically the emotional and instinctive roots of human behavior for the purpose of making over the person who is failing in his mental and social life.

From this it would seem that social psychiatry is in the position, not so much of supplying a new branch of social work, as of offering the psychology and the field work of the graduate course for all case-workers who wish to go beyond the level of intuitive psychology in dealing with the personality of the patient. I realize that this conception of psychology differs very markedly from the definitions which are sometimes given by psychiatrists or even psychologists, the former tending to limit psychology to the field of mental testing, the latter clinging to the normal or to the idea of pure science as opposed to practical applications. There is no reason why there should be a split between normal and abnormal psychology. If functional mental disease is not fundamentally related to the normal mind, if the processes of normal mental life cannot be seen working out in exaggerated forms in the behavior of the mentally ill, then mental disease is a foreign body which cannot be assimilated in our thought. Surely there is only one psychology of human behavior applicable to all minds, sick or well, and the psychiatrist found it first because he was actually forced to it by the necessity of getting some instrument for altering the behavior of his patients. The psychologist in the laboratory was not thus pressed.

If the psychology of tomorrow were to be limited to the field of mental testing for its only practical interest, then psychology might well be wiped out and psychiatry substituted. If psychology has no concern with human life beyond the testing of the intellect, it is not very much more useful than Greek to the social worker. At all events, what is meant by psychology in this discussion, whether you choose to label it psychiatry or psychology, is that science or art of untangling and reconstructing the twisted personality, of changing human behavior so that it adapts the individual to his environment, which is the basis not only of mental case-work and ordinary social case-work, but will eventually become the basis of educational method for normal and abnormal alike.

If one accepts this point of view, the question to be discussed is what qualifies an individual to do the psychological social case-work which is essential in social psychiatry and desirable for intensive case-work everywhere. Let us suppose we have before us the practical problem of passing on candidates for the training course in psychiatric social work. On what basis shall we accept or reject—if we are free to choose the most suitable?

The first point that is suggested is the matter of educational requirements. Is a college degree essential? Certainly the intellectual grasp, the appreciation of scientific method, the acquirement of a thought-out philosophy of life, the understanding of social problems and the training in psychology which the college degree ideally represents is highly desirable. As a matter of fact, a degree may or may not indicate adequate preparation.

Certainly this most subtle and difficult of all case-work requires not only an intellectual ability above the average, but an intellect which has been trained to tackle problems first hand and which has been equipped with a background of familiarity with the main trends of modern thought. The college graduate may not come up to these requirements, and the individual without the college degree may be found entirely adequate. It seems to me unfortunate to make the college degree a fixed arbitrary requirement if we can find any other way of determining whether the candidate is intellectually and educationally qualified.

Is it not possible to use a general intelligence test to exclude those whose intellectual capacity is not equal to this type of work and depend on case history as to education and previous experience together with some form of written examination which will give evidence of the candidate's general point of view, method of approaching a social problem and capacity for dealing with it at least theoretically? If this is possible, and the Pennsylvania School for Social Work intends to try it out next year, the intellectual qualifications can be settled without reference to any particular educational label and a high standard can still be maintained.

Intellectual ability with adequate training and background is certainly not the only requisite for the psychiatric social worker.

We have still to consider the age, personality and previous experience which fit an individual for the very delicate task of tampering with other people's minds and lives. Shall we accept the youngster just out of college, or must she have had some working experience? If so, what kind? Is the able, well-trained young person with a year or two of secretarial or business experience likely to be the one we are looking for or must a certain kind of experience be required? Again, should there be an upper age limit? Ought we to exclude a woman over forty from our training course? Some of us have seen children of twenty or twenty-one just out of college who, having completed a course in psychiatric social work, were floundering about hopelessly, chiefly because of immaturity and a general unfamiliarity with life, and have thought, "Heaven forbid that we should accept the inexperienced college graduate for psychiatric work!" Then there has been the older woman whose rigidity of mind, prejudiced attitude, and assurance born of successful experience have seemed to be insurmountable handicaps to learning a new type of work.

After all, within reasonable limits, doesn't it boil down to a matter of the particular individual and the kind of personality she possesses? If we arbitrarily exclude all candidates below twenty-five or over forty, we may shut out someone ideally qualified. What we are after is not any particular age but certain qualities which we fear to lose in the over-young or over-old. Certainly no one who is not intellectually and emotionally mature could be expected to enter into the emotional problems of others with understanding and confidence. Yet that is what psychiatric case-work implies. Maturity is not entirely a matter of age. It is sometimes lacking at thirty and present to a surprising degree at twenty in persons whose emotional experiences have been rich and conscious.

It seems to me that when we accept for training a girl just out of college or any girl of twenty-one, it should be either on the basis of evident emotional maturity or with the understanding that the student realize her limitations and gain experience in life and in the simplest problems of ordinary case-work before presuming to enter the psychiatric field. It may even be better to recommend to such an immature young person a preliminary social work training and experience before undertaking what perhaps should be only advanced training for the experienced worker. With the immature woman of mature years the case is more difficult because it is not so easy to detect the immaturity in the first place and because one must decide whether the lack of development is something which the course itself may be expected to alter, or whether it is a sign of a fundamental inability to make adult adjustments, in which case the candidate should become a patient rather than a worker. What can be used as a standard of maturity is difficult to say, but most of us have a 'feel' for gauging it and think we are able to size people up roughly in that regard, on the basis of a personal interview. This interview, combined with the candidate's way of dealing with the human problem presented in the written examination, ought to give a basis for judgment. The type of difficulty apt to be encountered in older women, rigidity, prejudice, unadaptibility, complete satisfaction with previous acquirements, must also depend on the personal interview and written examination for detection.

Given a well qualified person as to intellect, training and maturity, what weight should be placed on previous working experience? Everything else being equal, surely the candidate who had had experience in allied lines such as psychology, sociology, or social case-work, would be preferred to the inexperienced applicant. My own belief is that the person without previous casework experience is sadly handicapped and must make up for her lack by a longer apprenticeship in the simplest form of case-work. In other words, it is not possible to begin case-work at the top. But it is conceivable that a wide and intimate acquaintance with people might be a substitute for previous experience in formal case-work. Other types of social work, contact with social problems, practical work in psychology, all of these would certainly increase the potential value of the candidate for the course in psychiatry, but I doubt if any of them could be called prerequisites.

There has been a tendency in the past to consider nurse's training essential or very valuable for psychiatric social work. It seems to me that nurse's training in so far as it is directed solely to the understanding and care of the diseased human body is in itself no preparation for understanding the mental problems with which psychiatry is primarily concerned. This does not imply that the knowledge of physical health which the nurse possesses is not valuable as information or useful in practical situations but simply that it has no direct bearing on the peculiar contribution which psychiatry has to make to social work. In so far as most modern hospitals are training their nurses in public health work and medical social service from the beginning and are consciously teaching the psychological approach which should be used by the nurse in treating all classes of patients, they are giving a training which is preparatory to psychiatric social service, but such training is still far from universal.

As to the nurse who combines with her training, experience in wards of a hospital for the insane, if she possesses the other qualifications, her first hand knowledge of mental patients ought to give her a great advantage, but it does not in the least qualify her to undertake psychiatric social work with no other preparation. Without training in social technique, in all probability without anything but the most intuitive and unconscious psychology, and without understanding of social problems, she can have nothing to contribute to the work of the psychiatrist beyond the kind of thing she has done in the wards. This is not adequate for the supervision of the patient in his social setting where the doctor no longer knows or controls the details of the environment and cannot supply the knowledge and intelligence necessary to continue the after-care of a patient by any definite set of instructions which can be carried out literally and accurately. That is, psychiatric social work as herein defined must be enlightened, conscious and intelligent. It cannot be merely an exact and faithful carrying out of orders on the basis of military discipline. The psychiatric worker must make a real contribution, must supply the social knowledge and technique the psychiatrist necessarily lacks and must be capable of extending his usefulness beyond the clinic or hospital by intelligent interpretation of his ideas.

The value of previous experience as a teacher is also somewhat doubtful in my mind. It is the exceptional teacher who escapes the inelastic dogmatic attitude toward life which our public school systems seem to favor. That the right kind of teaching in the right kind of school would be the best of psychological preparation for psychiatric work, could hardly be denied.

Our discussion sifts itself down then to the following general and tentative conclusions. Given adequate intellectual ability and educational background for dealing constructively with the problems of human personality plus emotional maturity, all other qualifications such as age, previous experience, etc., are to be decided on the basis of the personality of the particular candidate with the single exception that experience in simple case-work either be a prerequisite or shall be covered adequately in the course itself.

One reason why it is so essential to have a fairly clear conception of the kind of personality that is fitted for psychiatric work is that the very nature of the field attracts persons who are interested in insanity or mental difficulties because of their own problems. It is possible to get a class with too large a percentage of potential patients if some care is not taken in sizing up the make-up of the candidate. This does not mean that only the most sane and normal make the best workers in this field.

Persons who are so simple, childlike and extroverted that they hardly know the meaning of personal life or emotional problems are too objective, too unself-conscious, too normal, if you will, for our purposes. They are unaware of their own mental life, they are likewise blind to the mental life of others. They should deal with things, not people.

On the other hand, the individual who is caught in the subjective phase, whose entire attention is turned upon her own conflicts, the painfully self-conscious person, is in no condition to throw herself into the life of another with a genuine objective interest in all of its difficulties.

Such a person is not free to work. The question is, is she so completely involved that nothing short of a psychiatrist can help her, or is it possible that the course itself will enable her to work out her own problems and eventually make her an even more valuable worker because of the experience. It is a matter either of attempting to decide on the potential capacity of the candidate for adjusting, or of rejecting all badly adjusted applicants. If the man who has had mental difficulties of his own and overcome them makes the best psychiatrist, as they sometimes say, may it not be equally true of the psychiatric social worker?

But, you say, shall our courses undertake not only to train workers but to adjust their personal lives? Unless we limit our students to the rare group of individuals who seem to have a genius for living and who adjust themselves without undue conflict in a normal, spontaneous development, and to the group of those who have consciously and successfully taught themselves to adjust to life, we shall be obliged to give time in our course to straightening out personal problems. . . . Social psychiatry brings these problems to consciousness inevitably, and interest is bound to center there until the student can work her way out.

True, she is not much good at case-work until she has settled herself, but in my experience, there seems to be no way of avoiding this period of subjective interest among students who are drawn from an imperfect world where most people are unadjusted and unfamiliar with mental hygiene. It seems to me this stage of absorption in the personal application of social psychiatry should be allowed for and the objective direction of attention not be expected until later.

It is difficult to list the personal qualities which render a candidate for the psychiatric course seriously undesirable and it is extremely difficult to pass judgment in concrete cases. Perhaps if we could draw a picture of the type of person who is born for the job, we should have a kind of norm by which to measure our applicants.

The born psychiatric worker, as I see her, has to be a maternal sort of person even if she is only twenty. She has to have a genuine liking for people and their troubles. It won't do for her to be at bottom cynical, carping and critical. She needs a warmth and spontaneity and whole-hearted interest that render the making of good contacts simple, natural and inevitable. I am inclined to think that she ought to be a settled person, a fairly satisfied person, who has a philosophy of life which she has tried out and can pass on with conviction and whose basic attitude toward life is a sober optimism. Without this, she will find it not so easy to throw her interest into the problems of every patient with perfect objectivity. The restless, unfulfilled, seeking, pessimistic individual cannot tear her attention loose from her own troubles long enough to manage other people's. Finally, the ideal psychiatric worker, like the old family physician, must be the person who has the strength to carry the patient, the poise which gives him confidence, the sympathy that means real understanding, the open mind which is always ready to try a new plan, the wisdom which allows the patient to work out his own salvation as far as he can, and the unending patience which is the rock on which he depends.

The personality that has strength and healing in its touch makes not only the great physician but the great social worker. The student who combines such a personality with the intellectual ability to use it to the best advantage or approximates such a combination is a safe risk for our course in psychiatric social work.

THE INDIVIDUAL VERSUS THE FAMILY AS THE UNIT OF INTEREST IN SOCIAL WORK*

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I HOLD that, whatever the ideal order, the practical order of work called "social work" begins with the eradication of evil. It may sound better to speak of sowing goodness, or transplanting goodness, or even grafting goodness in the eager social world, and beautiful little gardens of Eden or smaller oases of goodness can be shown here and there to the social visitor. Nevertheless I hold, with the prejudice of a physician perhaps, that eradications of evil are more in the first order of our work than disseminations, transplantations, and grafts of goodness. At all events, if there be anything at all in the millennial hopes and ingrained optimism of Spencerian evolution, it is plain that by and large we are putting evil behind us and arriving at goodness by a clever technique of successful destruction. To be sure, that destructive process is to our limited view a wholesale process, and it must be our conscious task to refine and differentiate that process or, by research, to discover other processes, as yet unknown to young Dame Nature, which shall convert the formula "survival of the fittest" to the plural form. There seems to be a fatal trend to monism whether you follow the British optimist, Herbert Spencer, or the German pessimist, Ernst Haeckel. But we are trying in America to live and let live, and to provide a sort of synoptical garden for all sorts of people, whether cross-fertilization be practically valuable for them all or not. We should be, should we not, *social pluralists* rather than social monists? Americanization, when it leaves us perfect at last, will leave us perfectly polychromatic and not the dull monochrome of the "average man" or the "economic man"—those sinister conceptions of the century in which all here were born.

Whether you agree or not with me in my conception of the primary importance of evil as the root of the social problem and whether you agree or not with my last year's formulation of the

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* Read before the Mental Hygiene Section, National Conference of Social Work, Atlantic City, June 3, 1919.

Kingdom of Evil,[*] you will probably agree (even Soviets might!) that evil must first or last be attacked. Holmes speaks, I think in the *Elsie Venner* preface, of puritan ladies who did not like *medicated* novels. There may be those who feel that social work is being over-medicated; but there should be none who would not medicate at all. I will leave my first point at this, then: there is not only a value but a necessity in approaching the social problem from the point of view of medical analysis. And I hope to show that even the problem of the normal family (provided that such exists as a social problem) is a problem profitably approached from the medical, and especially the psychiatric, side.

But I want to insist that, however much we analyze or employ scientific method in social work at large, in medical social work, or in psychiatric social work, we are still in the practical field, still within the confines of an art. We may be using science but we are behaving as practitioners of an art, the art of social work. Whatever may be said against that bungling term, at least "social work" has the grace not to call itself a science! Possibly you may not think it important to distinguish art and science. Thus you may know a great engineer who is a great physicist or *vice versa.* And the distinction is hard to draw, but at any rate Marshal Foch—also one of the most striking products of the nineteenth century, but not an "average" or "economic" man—makes much of the practical value of the distinction between art and science. Perhaps it is not too much to say that the Great War's issue hung upon the contrast between the practice of war as an art by the Allies under French influence and the practice of war as a science by the Germans. The science developed by Clausewitz almost won. But please do read Marshal Foch's own account (written at the turn of the century) of this whole matter. His story is a reasoned claim for war as an art.

We should then go to our social work as to war, first to eradicate evil and second to practice our best arts of social technique, eschewing all stuff and nonsense about any so-called social *science.* In the first instance our labors will be in a broad sense hygienic, and the more difficult our cases, the more likely our labors are to become not merely hygienic but to fall in the field of *mental* hygiene. The National Conference for Social Work appears of late, at least to the prejudiced and partisan view of psychiatrists, to have begun a slow but steady facing-about from economic and quietistic attitudes to a more pragmatic and even muscular posture of attack. Even the curious offensive-defensive attitude of the more Bolshevist members of our group is part and parcel of the new hygienic attitude of prevention (as well as cure) by destruction of elements conceived to be dangerous. The entire shift, both of conservative and of radical membership in the National Conference, is a shift, one might say, toward the technique of hygiene and especially of mental hygiene. Go to! Let us attack evil in every form, both crude and insidious, both material and spiritual, both environmental and personal! And let us abandon purely scientific schemata, however self-consistent and even historically successful these schemata may be, in favor of pragmatic plans.

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[*] The *Regnum malorum* has now one nomenclatural change (Litigia). The order of analysis runs *Morbi* (disease and defects, physical and mental), *Errores* (mistakes and misinformation or ignorance), *Vitia* (vices and bad habits), *Litigia* (not merely *Delicta,* crime and delinquency, but forms of being at-law), and *Penuriæ* (poverty and resourcelessness). Cf. *The Kingdom of Evil: Advantages of an Orderly Approach in Social Case Analysis.* By E. E. Southard, Proceedings, National Conference of Social Work, 1918.

But what is this new point of view called mental hygiene? Besides healing sores first and besides being pragmatic, what is the technique of mental hygiene? The technique of an art can profitably be examined in the type of its personnel. The personnel types are at least four and should be five:

a) the psychiatrist
b) the psychologist
c) the psychiatric social worker
d) the occupation therapeutist
e) the psychiatric nurse.

As for (e) the psychiatric nurse, even if she existed in respectably large collections in local or national associations of specialized nature, she would not especially concern us at this conference. For the nature and training of the nurse (including the public health nurse, and the psychiatric nurse, if such practically existed to stand for and wield a special power in mental hygiene councils) is emphatically not the nature and training of the social worker. A girl might become either, but could not, so far as I am aware, remain both. And most girls would not even start with equal potentialities for these two kinds of training. This is not to say that many a girl goes in for the wrong thing, that is, the thing wrong for her. Every day we see trained nurses who ought to have been and become social workers, but these transformed women for the most part are entirely conscious either that a mistake was made in their vocational choice at the beginning or else that the nurse's training accomplished no harm but was probably superfluous in the life of a social worker.

But for the most part it is idle to draw these distinctions with respect to mental hygiene, since the psychiatric nurse, as a standardized and self-explanatory figure in the nursing world, is wellnigh non-existent, and there is no body of accredited women from whom we could draw recruits for social work, even should we so desire. Signs are that this will not always be so. One of the next big steps in mental hygiene will be, I think, to develop the psychiatric nurse as a documented substantial entity, who can stand up in the work alongside other specialized forms of nurse, such as the surgical nurse and the public health nurse. And no doubt this movement will reverberate in the general field. For I consider that the problem, *How to put humanity into the trained nurse*, is a problem best solved by making every nurse do a successful piece of psychiatric nursing practice during her nurses' training course. And the mere existence of nurses who systematically received such training in psychiatry would in a few years leaven the entire lump and help to unbureaucratize the whole nursing situation.*

But these reflections have no special place here, unless they serve to push home the point that *social work is not nursing* and that psychiatric social work is not psychiatric nursing.

Nor should one dwell upon the equally obvious fact that (d) occupation therapy is not social work and that occupation-therapy workers are not social workers. Nothing was more evident in one's war committee contacts with these problems than that not only the training but also the temperament and interest suitable to social work were not at all those suitable either to nursing or to occupation therapy. The two latter run together far more smoothly than either with social work.

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*Hearers of these remarks have objected to me that the phrase "inhumanity of the nurse" is a little strong. Perhaps it is. Probably no women (with the exception of a few psychopaths) are properly described as not humane. My point in rather overdrawing the phrase "inhumanity of the nurse" is to emphasize the fact that there really is (to my view) a strong over-bureaucratizing influence at work in systematic training for nurses. It seems to me doubtful whether a good many women emerge from their training courses in some of the best hospitals, where quasi-military methods are pursued, quite as humane as they went in. Is there not some fire behind all the smoke of current statements that trained nurses have their eyes often too much upon the clock, upon the conventional rules of their profession, and upon what it is consistent with the dignity of a nurse to do? Has not a certain class spirit developed amongst R. N's? A good deal of this could be avoided, as I insist in the text, by passing nurses through experience in psychopathic hospitals. Indeed, I believe that in some parts of the country this plan has begun to be followed effectively.

Of the five actual or possible personnel types that mental hygiene now envisages, neither (e) the psychiatric nurse nor (d) the occupation worker nor (b) the psychologist has very much to do with family adjustments, and such adjustments as are furthered by this personnel get furthered rather through inborn powers of tact and ingenuity than through trained judgment and technique.

There is a sense in which psychiatry is a part of psychology, as medicine may be said to be a part of biology. Nor does the uninformed layman greatly distinguish the two fields, psychiatry and psychology. He is apt to speak of psychiatrists as "eminent psychologists" and wants to have every knotty problem solved "by psychology." In the list given above of personnel types in mental hygiene, I placed also the psychologist, but I was referring to workers in the field of mental tests and other estimates. These workers, who have enjoyed an extraordinary vogue and great success on all sides, apply methods devised by psychologists in the larger sense of the term. They are amongst the most effective of all workers in mental hygiene, despite the fact that they so soon come to the end of the rope. Such psychological examiners, as has been said, can often do more in an hour than a psychiatrist in twenty-four, or a psychiatric social worker in two hundred hours—but the psychological examiner can do very little *the second hour* with the same case. It is in any event plain that the psychological examiner, as at present developed, does not fall into competition with other types of mental hygiene personnel in the matter of family adjustments.

It remains certain, then, that in the present phase of mental hygiene the psychiatrist and the psychiatric social worker are charged with the main burdens of family adjustment. A slight study of records in intensive cases of psychiatric social work shows that time forbids the psychiatrist himself to indulge overmuch in the domestic details of family adjustment. For the psychiatrist can rarely give more than a total of from twenty-four to forty-eight working hours to a single case and in practice does not spend anything like so long on individual cases, except in the special field of psychoanalysis. On the other hand, some of our psychopathic hospital cases of intensive psychiatric social work have taken many hundred "social-worker hours" in the adjustment processes.

The moot question of the mental hygiene section of this year's Conference appears to be how far social psychiatry shall extend into the field of social work. Especially is it queried whether there should or should not be special social workers known as psychiatric social workers.

The mental hygienists in their surveys of the total field of medical social work were likely to prove almost too much. I don't know whether you can prove 49% or 51% or some other per cent of all cases of medical social work to have important psychiatric sides. I assume that these psychiatric features are so apt to creep into most social case problems that no medical social worker can safely do without her psychiatric lore. But it is equally obvious that a large minority of medical social cases are profoundly and from start to finish psychiatric, and that therefore there must surely be a group of more highly specialized social workers fitted by temperament, training, and choice to be psychiatric social workers. I conceive that at least as many as one in four of all medical social workers might well have been trained in some special training school for psychiatric social work, such as the Smith College School, the Philadelphia School, or the New York School of Social Work.

Be that as it may, it is true beyond peradventure that great numbers of so-called "family" cases are actually cases in which the entire economic or legal or moral or educational problem is not so much a family affair in the ordinary sense as an affair of a central psychopathic figure, surrounded by other family members virtually rooted to particular spots by the malign social influences emanating from the single source of evil will.

What may be called the "*psychiatric touch*" is therefore needed in an unknown but sufficiently large fraction of medical social cases, in such wise that there can be no doubt whatever of two facts, first, that all medical social workers should be trained in social psychiatry so as to make few initial mistakes and so as to pass their cases to more trained or enthusiastic hands, and secondly, that there should be a specially trained group of psychiatric social workers to whom these cases can be duly passed.

When I gave the title to the present paper, a captious critic might well have thought that I was somehow trying to replace the family altogether with the individual as a unit of interest in social work.* Now it should be obvious that, besides the individual and the family, we could also properly describe the neighborhood, the ward, the town or city, the county, the state, the nation, or even the newly conceived League of Nations, as perfectly proper units of interest in social work.

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* A Bolshevist wrote, congratulating me on the paper's title!

We might even proceed in the other direction. William James' conception of the selves that go to make up the human being is plainly just another group concept like the ones listed. The fact that a man may be his own worst enemy, or become afflicted with a totally unenlightened self-interest, shows how far this group doctrine of the selves might be carried. I have sometimes felt that we could well go back to our old grammars and study the active voice and passive voice for the elucidation of what goes on amongst the Selves (the Ego, the Me and the Social and Material Selves) as brilliantly formulated by James. The very opposition between Ego and Me suggests this application of the principle of the passive voice. For the Me in the objective or accusative case is clearly in a certain state of passivity. But I cannot dwell upon the alluring avenues of the group concept of the Self as Selves.

I simply here insist that by opposing the individual to the family as a possible unit of interest in social work, I am not denying the importance of the family when I extol the virtues of the individual as the object of social attention.

I am fond of quoting Miss Richmond's standard work on *Social Diagnosis* to show that a random selection of social cases, (such as Miss Richmond there makes for the purpose of bringing out certain points in social workers' technique) incidentally shows that a large minority, perhaps one case in two, of all social cases, has a strong psychiatric tinge. Accordingly, one of the things meant by my chosen title was that there must be a large fraction of cases in which the individual, rather than the family, will be the first point in a rational attack upon treatment. But that statistical fact, upon which the above contentions concerning psychiatric social workers' training were founded, is by no means the most important point which I am attempting to make in the adversation between individual and family.

If we employ the psychiatric touch in social-case families, we ordinarily, if not constantly, find that the central psychopathic figure in the family dominates the family. That domination may be objective and visible more to the social observer than to the members of the afflicted family; or again, the domination may be a subjective domination, amounting to an actually felt passivity on the part of the rest of the family.

Now my contention is that this observation of dominant figures in psychopathically affected families is not unlike the situation in entirely normal families. Of course, I do not wish to say that there are no normal families, though it is pretty hard to uncover an absolutely normal and perfectly adjusted family. Dr. Richard Cabot, at this conference, has picturesquely referred to the "dangers of perfect adaptation" on the part of anyone to his environment, and according to his formula it might well be that a perfectly normal family would make no more for progress than it would for the gayety or sorrow of the novelist. Be that as it may, the normal family, composed of Quételet's average men and women, would not naturally fall into the social worker's hands. It might even be playfully questioned whether the members of such normal families would make good social workers.

It was Schäffle, I believe, who attempted to replace the Spencerian individual with the family as the sociological unit. Gumplowicz later proposed the horde as the unit in sociology. But throughout these suggestions the individual retains a major interest. I propose that this manner of analysis (which I rather ineptly refer to as the "psychiatric touch") be applied to each family, and that the individualization of the family problem take the line of observing which member of the family is dominant over the others. It seems to me that everyday observation without further ado shows that almost all families are dominated by some one member. Sometimes, to be sure, these families are dominated in series so that, for example, the father dominates the mother, and the mother in turn her children.

This is no time or place in which to develop a rounded theory of logical attack on family analysis. But I think experience will prove that there is, as you might say, almost always a "*family handle*," that is, some member who is actually in control of the situation. The control, it is plain, need not be an externally strenuous or violent one; a *mollusk* might be the vehicle of control, as well as a *bull* or a *bear*.

I am inclined to think that families most greatly differ in the control by father and by mother respectively. May it not be possible that a comparison of family control under modern social conditions will be found very profitable with the phenomena of control under *father-right* and under *mother-right* in barbaric societies? We certainly see *patriarchates* and *matriarchates* in abundance all about us. More than one novelist has called attention to phenomena that one might think of as "daughter-right" or "son-right."* Better would it be to construct a logic of intrafamilial powers, such as $F > M$ or $M > F$, $D > F$, $S > M$, for the instances in which the father is dominant over the mother, the mother over the father, the daughter over the father and the son over the mother, respectively. And these formulae could be greatly extended. But I must leave this attractive vista of formulation to another time, and will leave the point at this, that the psychiatric manner of analysis may well be applicable even to those normal or nonpsychopathic families that the social worker has to deal with. This point will reduce, no doubt, to a study of the active and passive voice in the energy system known as the family. Accordingly, in my original adversation between the individual and the family, I intended to enclose at least two points, namely: first, that in a great number of family situations individual analysis is primary on account of the dominance of psychopathic figures in their midst and second that virtually all family situations whatever, will benefit by individual analysis as to what I call the *family handle* or dominant figure.

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*The *patriarchates* and *matriarchates* might be supplemented with *thygatriarchates* and *hyiarchates*. But this terminology is no doubt more amusing than practical.

MEDICO-PSYCHOLOGICAL STUDY OF DELINQUENTS

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THE most fundamental need of courts which deal specifically with human problems is knowledge of the qualities of the human beings concerning whom a decision is to be made and knowledge of the causes of the behavior which is the affair at issue. Why should there be the slightest expectation of doing anything like the best that can be done in court work without following the guiding principles of science and common sense which have led to all improvement and success in other fields? These principles involve, primarily, scientific acquaintance with material handled, with the relation of cause to effect, of adequately ascertained cause to ascertained effects, including the effects of court action. The application of such principles requires, here as elsewhere, the development of a technic of studying causes—which, as we can readily show, are frequently not at all superficial or easy of discernment—and requires, as well, building up a rational system of observing effects.

It is certainly not impertinent to the dignity of the law in this day of aiming at progress to ask why this particular department of human effort, this deciding of human affairs under the provisions of legal procedure, should in any way be exempt from investigations of efficiencies and of the causes for the failures which we all know exist in such large measure. Indeed it is no small matter for wonderment that there has never been any keen necessity felt by the legal profession for, at least, the sort of critical and interpretative statistical treatment of success and failure that is considered an absolutely necessary periodical procedure in other human activities. It is plain, however, that the special study of fundamental causes has lagged behind because it is only recently that a science of behavior has even been projected.

In this brief discussion of the part that medico-psychology can and should play in aiding solution of the problems of delinquents we especially desire to make clear its function in gathering, differentiating, and interpreting the facts of the background and of the possibilities in the given case. This may perhaps best be done by centering about a concrete case; the last one seen before this paper was written is typical enough in many ways.

A boy, 11 years old, is in court as a night vagrant; very repeatedly during the last few months he has been staying away from home all night and sometimes even two nights. The police have several times found him after midnight. His parents now appear with the officers to substantiate the complaint. The lad, Jim, is a very ordinary-looking boy, with nothing in any way remarkable about his appearance. What basis has the judge for decision in this case?

First, the lad's offenses: Anyone with experience or imagination can apprehend that this is a very important case because of danger for the boy's future, danger to him and to society. His night habits, wandering about and sleeping here and there, will probably lead him straight into a thieving career, perhaps into burglary; he is likely to become acquainted with sexual misdemeanors and to acquire bad sex habits; to say nothing of general lowering of his moral standards and conditions of health. The repetition of his misbehavior, of course, has greater meaning than a single escapade, but any wise judge knows that the bare fact of repetition of offense or of previous court record offers no criterion for safe judgment. The fact is that the day has long gone by when a decision concerning the juvenile offender can be regarded as good procedure if it is made merely on the basis of offenses, even as serious as the above.

The boy's age signifies little; many a long career of crime has begun as early. His nativity—he was born in Boston and his parents in Italy—denotes nothing in and of itself; similar misconduct is found equally among other nationalities, even our native stock. His physical appearance, his size and signs of normal health, offers no help for adjudication. The other facts presented to the judge—that the lad is normally advanced in school for his age and social group, being in the fifth grade, that the parents seem to be decent people and partake in the complaint, that he lives in one of the most crowded districts—likewise suggest no solution.

The judge proceeds further, giving time as the press of other cases allows. He learns that the parents are intelligent above the average immigrants—according to the officers they bear a good reputation and are not alcoholic—they are concerned about their boy and have searched for him at night. They say that until five or six months ago he gave no trouble; since then they have punished and scolded and begged him to do better. He has often promised, but very soon stayed out again. They know nothing of his companions or of his night doings; he does not answer when they ask him about this. He is a healthy boy, of good habits otherwise, and not peculiar in any way, as far as they can tell. The officers state that Jim engages in no other delinquencies; the boy bears a good reputation in school, except for occasional truancy. Then it comes out that he attends school often after he has been out all night. The boy himself insists that he always stays out alone and that he merely wanders about looking at things. Jim's attitude towards his parents is normal in the court room and he says that they treat him well and that he loves them. Finally, he states in ordinary boyish fashion that he does not know why he prefers wandering on the streets to sleeping in his own bed.

The judge has now given considerable time, nearly an hour, to obtaining skilfully a clear statement of these essential facts to supplement the investigation already begun by an officer of the court. Here is a case without obvious intricacies, but what are the real guides to rational adjustment? The parents in genuine solicitude say they are willing that Jim be sent to an institution, they have tried hard with him and have failed, the boy does not want to go and renews his promises to remain at home. At this point the judge, without pretending to know the real personality of the boy or the causation of his misbehavior, may make the shrewdest decision he can. (Of course, sometimes there is pretence from the bench of ability from vast experience, and so on, to make it possible to diagnose mentality, causation and what not even from an interrogation lasting a few minutes—but then from other judges comes the more ingenuous assertion that a judge is paid to make a guess in these matters, to be sure the best guess that he can make.)

On behalf of probation in this case the judge may think of the possibility of modifying behavior through fear of the court or through the friendly supervision of the probation officer. But, if we may judge by other careers which have begun with this type of offense, these general measures are not particularly likely to prove effective, since they cannot meet special needs which are really not known. The probation officer without specific knowledge has no specific remedy to offer. The other usual alternative, an institution for delinquents, is the easiest solution. But would it, either, meet the boy's individual problem? Everyone knows what an institution for such a case means: artificial conditions of home life, repression of many normal activities and interests of boyhood, companionship with other older and worse delinquents, costliness to the state, and so on. Puzzled, the judge may continue the case for further information. This ordinarily means nothing but gathering more facts about the objective features of the home life and neighborhood.

The point of view of medico-psychological study and diagnosis may now be considered: First, what can be known through ordinary court room observation of the physical make-up of this boy? He may have some significant defect or irritative condition, not at all suggested by his normal appearance. He may have astigmatism, and headaches in the evening, or even a heart lesion of which his parents do not know, or a hernia, or definite symptoms of some nervous disorder. Such physical findings may have significant relationship to causation, prognosis and treatment.

And the developmental history has not been ascertained; evaluated in the light of a careful professional inquiry it may be in some cases largely explanatory and show the limitations and possibilities of treatment for delinquency. For example, Jim may be subject to the slighter forms of epilepsy, readily overlooked, which in certain cases are so clearly associated with the impulse to wander. Or some fact of earlier disease or injury may throw light upon the present tendencies. The possible variations of antecedent causation are many.

The many facts told straightway in professional consultation, but rarely revealed in the court room, often include very significant data concerning heredity and family life, habits and behavior reactions of the young offender. And specially do we note that, naturally, this account of the boy's character and conduct often much more nearly approaches the truth than the picture given to the judge.

Most important of all, however, is what may be learned through medico-psychological study of the mental aspects of the boy's life. And we must insist, first and last, that by psychological inquiry we mean study of the functioning of ordinary normal mental processes and laws as well as possible abnormal phases of mental life. Mental habits, ideations, imageries, repressions, commanding interests, special abilities, particularized disabilities, form a field of greater importance for understanding, if one is really to know the total range of problems presented by delinquents, than is the discovery of mental defect and psychotic conditions which all recognize as one of the big single factors in the production of delinquency. In the dynamic features of mental life and in the mental content itself we have material for explanation and for re-direction and re-education that is invaluable. This is true even of some of the cases where there is abnormality of slight degree.

To come back to Jim, the fact that he answers fairly well the judge's questions, that he is reported to be in the fifth grade, means little concerning his mentality. He may be mentally defective in important ways and still be a fair conversationalist; he may possess the good memory powers characteristic of many of the feebleminded, and so have progressed to the fifth grade, or, on the other hand, he may be above average or even be a genius in some particular ability or in general, and yet be no further advanced in school. We are acquainted with just such irrational school advancements and retardations, and have seen many individuals whose mentality it would have been quite impossible to estimate as they appeared in the court room. To what extent the offender may or may not be psychopathic or what peculiar personality traits he may have is also not in the least revealed without special psychological examination.

And then without this study what can be known of the inner life in the aspects mentioned above? Who knows what he is thinking about or repressing, or what moods, or grudges, or feelings of limitation and conflict in his own household he may be harboring? The exciting cause or the underlying motive of such behavior, the force of which the experienced psychologist knows, ranges from such a general fact as feelings of distaste for old country standards in his home on the part of a young American to some secret, subtle revulsion against some one experience. Or what about an unknown hold of a bad companion upon the boy or some obsessive ideation concerning hidden knowledge, usually of sex affairs, one of the strongest driving forces towards delinquency?

It is perfectly clear, then, that to understand even the minor essentials of Jim's case he must be looked over physically and perhaps some special physiological tests made, and be given a full round of psychological tests, not alone grading him according to a mental age-level, but also looking for specialized features of the mental functioning, strong or weak, and that by the most skilful methods his inner mental life and mood and attitude be explained in its relationship to his misbehavior.

Accepting, as always, the challenge of the practical issue, we may meet the fair question,—What is ascertained through this study that the judge did not know, what facts that bear upon the really proper treatment of the case? Our answer is: The contributions are positive and negative; the latter quite as valuable as the former. It is as essential in Jim's case, for instance, to rule out epilepsy, chorea, syphilis, hysteria, psychosis, mental defect, and various other possibilities which we have found active factors in other cases of delinquency, as it is to discover that he is physically healthy and particularly energetic, and that he is highly supernormal in general mental ability and possesses dynamic qualities that demand much in the way of interests, activities and new material to satisfy them. Likewise careful summation of data shows that there are probably no very significant facts of heredity and development bearing upon the boy's tendency to delinquency. Analysis of the boy's reactions as exhibited in his own account of them shows no indication in this first study of him that there is clash of ideals in the household, and that no bad attitudes and grudges have been formed. For the more positive side, it stands out clearly that though the household is well managed and favorable in many ways for the development of a boy of the most mediocre capacities and though there is quite normal affection displayed, there has been no understanding whatever of Jim's peculiar needs (perhaps this has led to a certain reserve which Jim shows towards his parents but has not exhibited elsewhere) and there is very little at home to hold the interest or provide outlets for such an active minded and capable lad.

The necessary careful psychological analysis of effects of influences outside the home shows early acquaintance with bad companions, rejection of their modes of conduct, dwelling on ideas of adventures in city life received from them, a first taste of it alone and, then, following the laws of repetition of pleasurable effect and of mental habit, frequent renewal of adventures in which much that was new and of great interest was experienced. Always alone, Jim found in his night wanderings satisfaction not obtained elsewhere. In the early morning hours, for instance, he would be held by the romance of huge printing presses turning off newspapers of the day.

The essence of such study is the focussing and interpretation of sufficient data, negative and positive, for the purposes of treatment. Brought together and evaluated are many more facts and even types of facts than the judge in court can ascertain. The way to a better adjustment of the situation concerning Jim is now obvious. It cannot be doubted that an institution would probably be his undoing; it is equally clear that there are special measures which very likely will prove reconstructive, even if he remains at home.

The above features of this interesting case were sufficient to make its presentation of value for a general audience. But for this paper it should be stated that when the study had proceeded thus far our records show that we felt the possibility of there being much more to the whole affair. The professional reader will be particularly interested in what follows. Although Jim told us of certain peculiar and strong impulses which assailed him so that while at times he was in the mind to go home from school, at other times something came into his head which impelled him to stay out, yet the deeper explanation concerning these impulses could not at that time be ascertained. We appreciated, however, that Jim was repressing much.

His later behavior was most significant. Possible fear of court action held him so little that within a couple of days after his return home he left again and was gone three days. Upon his reappearance in court we made further attempts to get at the true underlying facts. Queer phases of his "forgetting," especially the name of a companion, now appeared which seemed most significant to us. We took pains to find from other sources who this boy was. Then with the name given, Jim suddenly "remembered" and began a typical story of mental conflict. Fitting in with what we had learned specifically about the character of this other boy was Jim's description of most unfortunate learning from him of sex affairs and night adventures. Jim, however, had never stayed out with this boy.

There was much of interest centered about sex words coming up in Jim's mind, associated with impulses to masturbation on the street at night and desire for free night life. The whole picture, the many details of which, of course, could not be given in a few pages, presents the mental mechanisms familiar to students of conflicts. There was the original deeply emotional experience, the definite association at this time of at least two main ideas of delinquent behavior, specific efforts at repression of one of the main components, the formation of a typical complex, the dynamic outlet found in night adventure.

Now, with these facts ascertained, the specific reconstructive measures to be undertaken are at last clear. There must be breaking up of old associations and initiation of measures adapted to re-education. If we may judge by many other cases seen and followed up, we now have the clue to the needed modification of Jim's behavior.

Summing up: We know on the basis of long experience that such medico-psychological study frequently brings out points that are absolutely essential to knowledge of causation which, in turn, is the only rational approach to treatment. Short cuts to such knowledge are not possible; why should one expect to find them, considering the complexities of human behavior and mental life? And what are hours of study compared to months of effort which may be unnecessary, as in institutional life, or ineffective and misdirected under probation?

Without desiring in the least to usurp the functions of the law, and without the least argument against punishment in appropriate cases as a good therapeutic agent, and holding no brief for any theory of either causation or treatment, we may insist on such study as representing a minimum standard of welfare in the treatment of delinquency. A rational method of meeting the needs of the youthful offender, which indirectly affords, of course, the greatest protection to society by thwarting his prospective career, is only to be developed by utilizing the facts acquired through a good technic of medico-psychology. This procedure, carried out with sympathy and thoroughness, will contribute greatly to the effectiveness of courts and of other human agencies which attempt some solution of the problems of delinquency. Many of the huge number of failures which occur under the ordinary system it will be possible to avoid. Moreover, evaluating any method or régime as conducted under court or institutional auspices is rationally possible only when the essential facts of causation and potentialities of the human material handled form the basis of judgment.

BETTER STATISTICS IN CRIMINOLOGY

HORATIO M. POLLOCK, PH.D.
Statistician, New York State Hospital Commission

THE prevention of crime and the apprehension and punishment of criminals have constituted one of the principal functions of government from primitive days down to the present time. Many systems of penology have been tried from the eye-for-eye and tooth-for-tooth system of ancient Israel to the modern system of probation. Some systems have been discarded because of their inhumanity and others because something more promising was offered. The idea that it is quite possible to determine the efficiency of various methods of dealing with criminals is comparatively new; practically no provision has been made for studies along this line. In criminal procedure we are still living in the prescientific age, and we are not using the experience of the past in a profitable way to guide either our present or future action. Those who have studied criminology intensively are agreed that most of our present methods of dealing with criminals are unsatisfactory. In our criminal system in general we are not preventing crime and we are not reforming the criminal. Our detention homes and jails are elementary schools in misconduct; our penitentiaries and reformatories are secondary schools in crime, and our state prisons are practically colleges of criminal arts. The adept student quickly goes through the whole course and often returns for post-graduate study.

Ignorance concerning crime and criminals in this country is appalling. For the United States as a whole we have no means of ascertaining the number of crimes committed, the number of arrests made or the number of convictions resulting therefrom. We cannot compare convictions with arrests or crimes, nor either of these with the general population. We do have decennial federal statistics of the inmates of penal institutions and of the commitments to such institutions, and we have some state statistics dealing with the same matters, but it is practically impossible to compare results in one state with those in another.

Our national failure to compile adequate statistics in criminology has frequently been pointed out. Eugene Smith, President of the Prison Association of New York, at a meeting of the

American Prison Association in 1911, stated that the foreign delegates to the International Prison Congress held in Washington in 1910, "could not repress their amazement at the dearth of official statistics regarding crime in the United States. Possibly it may be doubted whether any of the novelties they observed here produced on their minds so lasting and injurious an impression of this country, regarded from the point of view of scientific penology, as was caused by the meagerness and practical inutility of our criminal statistics." Dr. Frederick L. Hoffman, the well known statistician of the Prudential Life Insurance Company, in a preliminary report on statistics of crime and criminals presented to the American Prison Association in 1915, refers to the condition of criminal statistics as being "chaotic and confusing" and states that "there is conclusive evidence of the necessity for a nation-wide public interest in the need of a thoroughly well considered, scientific and largely statistical study of the problems of crime and criminals and all that is more or less pertinent thereto." John Koren, another leading authority in the statistical field, in an address before the Prison Association in the same year, sums up the situation in these words: "The ever-growing demand in this country for statistical information about crime has become pathetic. It is like a cry in the wilderness that only wakens its own echo. Year by year committees of this Association, explaining the situation, have plead times without number not only for nation-wide statistics of crime and prisoners, but for improvement of the reports made by the officials who direct our penal institutions. No one can doubt the strength and genuineness of the demand for facts, nor has there been a lack of practical suggestions and recommendations. But what has been the response? Statistics of crime in the form of competent returns from the criminal courts of the country are utterly wanting. In isolated instances certain courts tell more or less fully about their work, but, generally speaking, there are no serviceable reports of crime as exhibited by the operation of the criminal courts. Judicial statistics in the proper sense we know not in this country."

Miss Annie Hinrichson, inspector of institutions for the State Charities Commission of Illinois, in giving an account of the efforts made to establish a system of criminal statistics in that state in 1916, states "that a general survey of the methods of collecting criminal statistics in other states was made. This survey proved both disappointing and discouraging. With the exception of Massachusetts the other states had little to offer in the way of either general summaries of statistics or intensive studies of the causes and conditions of crime in typical communities."

Special studies of delinquents by individual investigators such as those made by Dr. Bernard Glueck at Sing Sing, and by Dr. William Healy at Chicago and Boston, have given us an insight into some of the real problems of criminology that the state and nation must solve, but general progress in dealing with crime and criminals will not be made until we have assembled facts sufficient to guide our action, nor until such facts become known to our legislatures and courts. Thus far, the legal methods of dealing with crime have been based principally on precedent and tradition and while the failure of these methods is generally conceded, we lack the data necessary for the establishment of a better system.

The special function of statistics in any branch of sociology is to assemble the facts that must be dealt with and array them in an orderly, systematic fashion so that their meaning and interrelations may be readily comprehended. Without statistics there could be no sociology worthy of the name, and without good statistics little social progress is possible.

It seems hardly necessary to emphasize the fact that some aggregations of numbers are not statistics. Many of the collections of figures assembled in various states under the heading of criminal statistics are wrongly named. In some cases it would have been more fitting to call them clerical diversions. These so-called statistics were well characterized by William T. Cross, Secretary of the National Conference of Social Work, in an address before the American Prison Association in 1916 when he said, "The statistics for the most part are gathered in a crude fashion, and published, if at all, with little scientific analysis. The primary faults of the judicial statistics are their lack of scientific standardized classification and definition of crimes, and of facts descriptive of the social condition of the criminal and the circumstances of the crime. The chief faults of the institution statistics are their meagerness, lack of uniformity and unreliability and the limited use made of them by the central authorities." What more could be lacking?

To study crime and criminals statistically we must first formulate the purposes of the study. So far as I am able to ascertain, such purposes have never been fully stated. Those that seem obvious to me are hardly touched on in available statistics in this field. Briefly summarized these purposes are:

1. To give a general survey of conditions with respect to crime in the nation as a whole and in the several states and their various civil divisions. Such a survey would show the crimes committed, the arrests made, the convictions resulting and the disposal of the offenders. A statistical survey of this kind, if made in the same way year by year, would show the trend of crime in the various states and their subdivisions and would furnish data for accurate comparisons of results in different states and localities.

2. To show the effects of various methods of treatment on persons convicted of crime. This study would be intensive and would enable comparisons to be made between the traditional and the experimental methods of dealing with criminals.

3. To enable society to prevent crime. To accomplish this purpose would require a thorough statistical study of the causes of crime and the genesis of the criminal.

Before statistics can be compiled to accomplish these purposes much preliminary work must be done. The following requirements are indicated:

1. The adoption of a uniform classification of crime and criminals by all federal and state authorities. The lack of a standard classification is the primary obstacle in the way of good statistics in criminology. The ordinary classification of crime found in state statistics uses terms adopted from the penal laws of the state. Many of these terms are loosely applied and have little significance from a social or scientific point of view. The classification of criminals is even less uniform and less adequate. In the federal statistics of criminals and juvenile delinquents, the prisoners are classified throughout by the crime for which they were committed. When it is well known that a person may commit a dozen different crimes before being convicted of one, to label him by the name of the crime for which he is convicted serves little purpose.

How is an acceptable classification of crime and criminals to be made? It can be done only by the generous and thoughtful cooperation of experts in criminology and statisticians with governmental agencies in state and nation. A beginning might be made by the appointment of a joint committee of all national societies interested in the general subject of delinquency. The United States Census Bureau and the Prison authorities of several states should be represented on this committee. In the light of the present knowledge of crime and criminals, such a committee should have but little difficulty in agreeing upon a rational classification. The next step would be to secure the general adoption of the classification by federal and state authorities.

2. The second requisite for good statistics in criminology is uniform statistical records and reports. With a standard classification at hand, it would be an easy matter to prepare blanks for a definite statistical record of each crime reported and of each individual arrested and tried. Uniform statistical reports could readily be made from such standardized records.

3. A new system of this kind to be successfully introduced must be handled by central statistical bureaus. It could be done by the United States Census office or by statistical offices in State Prison Commissions or by well-equipped private agencies. The great difficulty in the work of private agencies is the lack of authority to demand correct records and reports. The central statistical office, whether state or federal, would provide standard forms to all agencies making records of crime and would require that the records be accurately kept and that full reports be made. This would, of course, necessitate the employment of competent clerks in the office of recording agencies. It is probable that the best results would be obtained by having separate card reports made of each crime, and of each arrest and conviction. In the central statistical office provision should be made for filing together all reports relating to the same person.

The system herein briefly outlined is very similar to the one now being used in compiling statistics on mental disease in New York State, and, through the joint efforts of the American Medico-Psychological Association and of the National Committee for Mental Hygiene, a similar system of statistics on mental disease is being introduced throughout the United States. Four years ago statistics on mental disease in the country at large were no better than present statistics of criminals, but through cooperation a great improvement has already taken place. Success in this field seems to point the way for action in the field of statistics in criminology.

In our system of dealing with crime and criminals we are standing, as it were, on the boundary line of a new country. Behind us, but close at hand, are the dismal swamps of ignorance, intolerance and cruelty; before us, in the distance, lie the fertile plains of knowledge, justice and goodwill. It remains for us to go forward and possess the land.

OBITUARY

Morris J. Karpas

Major, Medical Corps, U. S. Army

Morris J. Karpas was born in Petrograd, Russia, on March 25, 1879, and came to the United States at the age of thirteen when his whole family immigrated to this country. He was of Jewish parentage and owing to the educational restrictions imposed upon Jews in Russia he was unable to go higher than the elementary schools, but he received a very good literary foundation in private schools and from tutors at home. During intimate talks about his education in this country he often expressed his deep sorrow at the fact that stress of circumstances prevented his parents from sending him to college. He was forced to go to work soon after he came to the United States in order to assist in the support of the family. However, his thirst for knowledge was such that although he worked hard during the day, he attended regularly the Evening High School and other educational centres and assiduously prepared himself for the study of medicine.

It was in 1900 when I first met Morris J. Karpas. We were both teaching in the same Evening School in New York City and both of us were studying medicine. He graduated from the Long Island Medical College in 1904, and on November 1st he began his hospital career as an interne in the Manhattan State Hospital, N. Y. C. Both by temperament and intellect Dr. Karpas was eminently fitted for the study of mental and nervous diseases. He was a patient and painstaking worker, a keen observer, and a clear thinker with a strong imagination. He was anxious to learn, and entertained a grateful reverence for his teachers and superiors, not often found nowadays. Dr. Karpas frequently told me how fortunate it was for him that he had been in the Manhattan State Hospital during that transitional period when Adolf Meyer with his staff of skilled and indefatigable assistants reorganized the scientific elements of the N. Y. State Hospitals. Like many others he witnessed the disappearance of the old and effete ways of study and treatment and saw them replaced by the more sane and scientific methods of the new schools. He grew up, as it were, with the new system and entered right into the spirit of it. He attended meetings and participated in discussions, he was a prolific reader and contributed reviews of articles and books from German and Russian literature to various journals, notably the *Journal of Nervous and Mental Disease.*

In 1909 Dr. Karpas went abroad and spent some time in Berlin, Vienna, and Zurich, where he did special work in various clinics. In April 1912 he resigned from the Manhattan State Hospital and decided to remain as assistant physician in the Psychopathic Pavilion at Bellevue Hospital where he had been since November 1911. He went into private practice in the Fall of 1915.

Throughout all these years Dr. Karpas wasted no time; when he was not busy with his patients he devoted most of his time to reading and writing. A glance at the index of any medical library shows that he was a man of broad interests, that he did not confine himself to psychiatry and neurology but, like every student of mankind, he was equally interested in psychology, sociology and kindred subjects. How versatile he was can readily be judged by the titles of even a few of his contributions: *Clinical Significance of the Cerebrospinal Fluid in Nervous and Mental Diseases; Kraepelin's Conception of Paraphrenia; The Principles of Freud's Psychology; Remarks on Neurology and Psychiatry in Berlin with special reference to Zieben's Intelligence Test; The Psychopathology of Prostitution; General Paralysis of Unusually Long Duration; Criminology from the Standpoint of a Psychiatrist;* and *Socrates in the Light of Modern Psychology.*

Dr. Karpas volunteered his services shortly after the war broke out and was commissioned a captain; he was made a major just as he was about to sail for France in March 1918. He died suddenly in France from angina pectoris on July 16, 1918, while in the service of his adopted country. Judging by the reports of his superiors and his fellow officers Major Karpas was as active and made himself as indispensable in the army as he had been in civil life. In the words of his colonel and friend, Pearce Bailey, it was not soldiering that characterized his activities in the army, it was duty. Such was also the verdict of his colleagues, the medical officers of Camp Zachary Taylor, as expressed in their resolutions on the occasion of his death. Whoever came in contact with him soon felt his force of character, his loyalty and devotion, and his love for mankind. Having himself experienced the vicissitudes of life he could read himself into his fellow beings and could truly say "*Haud ignara mali miseris succurrere disco.*"

A. A. Brill.

ALFRED GLASCOCK

Captain, Medical Corps, U. S. Army

Dr. Alfred Glascock died October 10th in France, being at that time a captain in the Medical Corps of the Army. Dr. Glascock had specialized in neurology and psychiatry ever since his graduation and among his friends was known to be extremely well versed in these specialties. A strong antipathy to publishing his studies made his name less known to the world of psychiatry at large than it would otherwise have been; in fact, he only seems to have overcome this reluctance to appear in print on two occasions. He published *Report of a Case of Little's Disease* in the *New York Medical Journal* for September 1, 1906 and to the *Journal of Nervous and Mental Disease* for March and April, 1913 he contributed *The Present Knowledge of the Status of Apraxia, with the Study of a Case.* This latter paper was in reality a small monograph and contained a large amount of original material, all of which was worked out in painstaking detail. It was probably the best study of apraxia in the English language and indeed had been referred to as such editorially.

Dr. Glascock was the son of Captain Alfred Glascock of the Confederate Army. He was born in Leesburg, Va. in 1881, was educated in the Episcopal High School near Alexandria, Va. and graduated from the Medical Department of George Washington University in 1902. He served a few months in the Foundling Asylum and then came to St. Elizabeths, where he served continuously for fifteen years with but one interruption, when he took an assignment for six months at Ellis Island as psychiatrist in the Immigration Service. He was successively interne, junior assistant physician, assistant physician and senior assistant physician. At the outbreak of the war, true to the military traditions of his family, he made strenuous efforts to get into active service but his hospital was strongly disinclined to spare him. Finally, however, in the spring of 1918, he resigned from St. Elizabeths Hospital and was shortly afterwards commissioned a captain in the Army. He went to Camp Hancock, Ga. in May as special examiner in psychiatry and in September went overseas as part of the staff of a base hospital in the interior of France. Shortly after landing he developed pneumonia, to which he quickly succumbed.

Dr. Glascock was a quiet, unassuming worker in his special field, never seeking to attract attention to himself at medical

GUY C. HARALSON

J. FREDERICK MUNSON

meetings or by rushing into print, but he took a deep and genuine interest in the patients under his care. Many of these latter still refer to him frequently and no doubt will do so for years to come. Perhaps this is the most sincere tribute which can be paid to his memory.

J. E. LIND.

JAMES FREDERICK MUNSON

Captain, Medical Corps, U. S. Army

War brings many changes in the lives of men. Some are permitted to go through to the finish, to see their own hopes and those of their country realized, and to enjoy the reward and pleasures that come through victory. Though those who are not so fortunate as to see the end and are taken earlier are deprived of these things, yet the work of a good soldier is never forgotten, and the influence and example set has a broader effect than is often appreciated. In the death of Captain James Frederick Munson, Medical Corps, United States Army, such was the case, and the Neuro-psychiatric Service of the Army suffered a great loss.

Captain Munson was one of the first officers assigned to duty at General Hospital No. 30, Plattsburg Barracks, New York, the Army's special hospital for neuroses. From the beginning his work attracted great attention on the part of those with whom he was associated. His special aptitude for the military service coupled with his untiring efforts and unusual ability had much to do with the success of a new and difficult undertaking. Had he been permitted to live and carry out the work he had outlined for the special study of convulsive conditions, a great deal would have been added to our present knowledge of this subject.

Captain Munson was born June 19, 1881 at Pontiac, Michigan. He was graduated from the University of Michigan with the degree of Bachelor of Arts in 1902, and Doctor of Medicine in 1904. From 1904 to 1906 he was an assistant in the laboratory of Dr. V. C. Vaughn, going directly from there as Resident Pathologist, Craig Colony for Epileptics, where he remained until he was commissioned as a captain in the Medical Corps, United States Army, March 2, 1918. He died October 25, 1918 at U. S. General Hospital No. 30, Plattsburg Barracks, New York, after a short illness with pneumonia following influenza.

Captain Munson was an officer who was willing to sacrifice all his personal desires for the good of the cause for which he was working. He was loved and admired by all his associates, and considered an unusual friend by all the patients. When the time came to pay the last respects as his body was removed from the hospital to the station on the journey to its final resting place, a most significant and noticeable tribute was paid by a large group of patients who, at their own request, marched behind the body as evidence of how much they felt the loss of their great friend and physician.

While Captain Munson was taken before he was able to put the results of his work on paper, yet those with whom he worked, and the patients whom he helped, will always hold him in their memory as one who gave his all in a most patriotic and unselfish way for his profession and his country.

T. D. WOODSON.

HEIMAN CARO

Captain, Medical Corps, U. S. Army

Doctor Heiman Caro gave up his work at the Monson State Hospital at Palmer, Massachusetts, in August 1917 to enter the Army. He was commissioned a lieutenant in the Medical Reserve Corps and assigned to Camp McClellan, Anniston, Alabama. Later he was sent to Camp Grant in Illinois and then to Fort Snelling, Minnesota, where he received his orders for overseas duty. He left New York in October 1918 as a captain, and was assigned in France to Base Hospital 107, at Nevers where he rendered valuable service to the sick and wounded of the American Expeditionary Forces. He contracted pneumonia and died at Base Hospital 35, at Nevers on January 22, 1919. He was buried with military honors in the American Military Cemetery.

Doctor Caro was born in Chelsea, Massachusetts, on August 17, 1889, and although he died when only twenty-nine, at the very beginning of his career, he had already given splendid promise of attaining high rank in his work. He graduated from Harvard University in 1911 and from Harvard Medical School in 1914. He was a staff officer at the Boston City Hospital until he entered the Monson State Hospital in 1915. He had devoted his time and energy to the special study of mental disease. Previous to entering the military service he had on invitation read papers at medical meetings in Atlantic City and Philadelphia on *Syphilitic Symptoms in Epilepsy*. A posthumous article by him appeared

HEIMAN CARO

in the *Journal of the American Medical Association* recently, entitled *Idiopathic Enuresis.*

Doctor Caro had a wide circle of friends. He was a man of extremely attractive personality; modest, and unassuming, but alert and keen in a crisis. His devotion to his parents and his home, and his love for his country for which he made the supreme sacrifice, stamped him as a man of unusual fineness of character.

GUY CHAILLÉ HARALSON

Lieutenant, Medical Corps, U. S. Army

Lieut. Guy Chaillé Haralson entered the Medical Corps of the U. S. Army early in October 1918 and was assigned to duty with the Neuro-Psychiatric section, General Hospital No. 6, Fort McPherson, Georgia. Very shortly afterward, he was taken ill with pneumonia, complicated by influenza, and died on October 24, 1918.

Lieut. Haralson had specialized in mental and nervous diseases and had been assistant physician at the East Mississippi State Hospital for the Insane, from the time of his graduation from Loyola University, Chicago, in June 1917 until he entered the Service. He was born in 1882 in Biloxi, Mississippi, and was the only son of Dr. H. H. Haralson and Belle Loch Haralson of Harperville, Mississippi.

There is something peculiarly tragic in a death such as Dr. Haralson's. He was only 36 and at the beginning of his career. He had been married only two weeks. Although like hundreds of others, he made the sacrifice of his home and his profession, unlike the majority of them and of the many who died in France, he was denied the privilege and satisfaction of service at the front. To him no less than to those more fortunate others, is due the supreme honor and gratitude of the country for which he died.

R. M. BUTLER.

NOTES AND COMMENTS

Florida

A bill to establish a farm colony for feebleminded and epileptics has been enacted by the 1919 legislature. An appropriation of $200,000 is included in the bill.

Kansas

Senate Bill 553, providing for voluntary admission to a state hospital for mental disease, which was briefly summarized in the last number of MENTAL HYGIENE, was passed by both houses of the legislature and has been approved by the governor.

Section one, Chapter 230, Laws of 1919, reads as follows: "No woman under the age of forty-five years, or man of any age, except he marry a woman over the age of forty-five years, either of whom is epileptic, imbecile, feebleminded or afflicted with insanity, shall hereafter intermarry or marry any other person within this state. It shall be unlawful for any person to marry any such feebleminded, imbecile or epileptic person, or anyone afflicted with insanity. Children born after a parent was insane shall not marry except under the above-named conditions, unless the parent or parents of such children shall have been discharged from the State Hospital for Insane or any other legally constituted institution for the treatment of the insane more than nine months before the birth of the child, as cured and remained cured for a period of twenty years after such discharge."

The Hospital for Epileptics, at Parsons, has received an appropriation of $7,000 to be expended as follows: for the construction of an ice plant, $4,000; for an implement shed, $1,500; and for a cattle shed, $1,500. The sum of $1,500 has also been appropriated for fire escapes at the State Training School. The Larned State Hospital is to have a new dairy, for the construction and equipment of which $10,000 is appropriated for the year 1921. This hospital has also received an appropriation of $18,500, to be used in 1920, for an addition to one of the cottages, and $5,000 for an ice plant. The Osawatomie State Hospital has received an appropriation of about $50,000 to be expended for various improvements. The Topeka State Hospital has been granted the sum of $18,000 for 1920, and $20,000 for 1921, to be used for improvements.

Missouri

The governor has vetoed the bill which would provide for the supervision by the state superintendent of schools of the instruction in all state schools for children, outlined in the April number of MENTAL HYGIENE. The bill for the commitment of the feebleminded, which passed both houses without opposition and was one of the few bills passed without any change, met a similar fate at the hands of the governor. It is probable that each of these bills will be reintroduced in the next legislature.

Pennsylvania

A bill, introduced in the 1919 legislature, to provide for the sterilization of patients in hospitals for mental disease and institutions for the feebleminded failed of enactment.

Tennessee

A "general insanity law" was enacted by the 1919 legislative assembly. The first section of this law changes the names of the state hospitals by eliminating the word "insane." The act outlines the legal process to be followed in the commitment of a person to these hospitals, who must have a hearing before the county judge or chairman in the presence of witnesses. The county judge or chairman shall determine the number and character of the witnesses, except that there must be at least two reputable physicians, duly authorized to practise medicine in Tennessee, who shall have had at least three years' actual practice. Each of the physicians must make a physical and mental examination of the person and record the results on a written certificate in accordance with a specified form. Each certificate must be sworn to by the physician. The physicians may also be examined orally. Among other provisions, the act divides the state into hospital districts, prescribes the powers and duties of the Board of Control, defines the rights and obligations of the insane and of their relatives and guardians with reference to them and their property.

Wyoming

The State Hospital for the Insane has received an appropriation of $90,000 for the completion and equipment of a new building and $12,000 for the purchase of additional farm lands. The sum of $25,000 has been granted to the School for Defectives for the construction of an addition, $5,000 for the erection of a power house and $1,000 for installing and equipping an enclosed playground.

OCCUPATIONAL THERAPY

Many workers in Occupational Therapy who have good technical training but who lack experience in instructing mental and nervous patients are therefore not eligible for this important work in neuropsychiatric hospitals. This experience must be gained under supervision and advice.

A limited number of qualified workers who desire to fit themselves for this work may arrange for a short period of practice in this field at a nominal salary at Bloomingdale Hospital, White Plains, New York, and at the Pennsylvania Hospital for the Insane, Philadelphia, Pennsylvania. Application should be made to the superintendent.

A period of practice and instruction may also be obtained by a few workers at the Sheppard and Enoch Pratt Hospital, Towson, Maryland, under conditions which will be explained on application to the superintendent.

To Promote Occupational Therapy

A National Association for the Promotion of Occupational Therapy has been organized indicating that the movement has grown to proportions which need the stimulus of national contact. The association has agreed upon a platform of principles which express the object and purposes of occupational therapy and the results expected to be produced through its development, as follows:

(1) Occupational Therapy is a method of treating the sick or injured by means of instruction and employment in productive occupation.

(2) The objects sought are to arouse interest, courage and confidence; to exercise mind and body in healthy activity; to overcome functional disability; and to re-establish capacity for industrial and social usefulness.

(3) In applying Occupational Therapy, system and precision are as important as in other forms of treatment.

(4) The treatment should be administered under constant medical advice and supervision, and correlated with the other treatment of the patient.

(5) The treatment should, in each case, be specifically directed to the individual needs.

(6) Though some patients do best alone, employment in groups is usually advisable because it provides exercise in social adaptation and the stimulating influence of example and comment.

(7) The occupation selected should be within the range of the patient's estimated interests and capability.

(8) As the patient's strength and capability increase, the type and extent of occupation should be regulated and graded accordingly.

(9) The only reliable measure of the value of the treatment is the effect on the patient.

(10) Inferior workmanship, or employment in an occupation which would be trivial for the healthy, may be attended with the greatest benefit to the sick or injured. Standards worthy of entirely normal persons must be maintained for proper mental stimulation.

(11) The production of a well-made, useful, and attractive article, or the accomplishment of a useful task, requires healthy exercise of mind and body, gives the greatest satisfaction, and thus produces the most beneficial effects.

(12) Novelty, variety, individuality, and utility of the products enhance the value of an occupation as a treatment measure.

(13) Quality, quantity, and salability of the products may prove beneficial by satisfying and stimulating the patient but should never be permitted to obscure the main purpose.

(14) Good craftmanship, and ability to instruct are essential qualifications in the occupational therapist; understanding, sincere interest in the patient, and an optimistic, cheerful outlook and manner are equally essential.

(15) Patients under treatment by means of occupational therapy should also engage in recreational or play activities. It is advisable that gymnastics and calisthenics, which may be given for habit training, should be regarded as work. Social dancing and all recreational and play activities should be under the definite head of recreations.

FOR BETTER COMMITMENT LAWS

The National Committee for Mental Hygiene appointed in December a Committee on Legislation, consisting of Doctor George M. Kline, Chairman of the Massachusetts Commission of Mental Diseases, Chairman; Doctor Charles W. Pilgrim of the New York State Hospital Commission; Doctor Owen Copp, Superintendent of the Pennsylvania Hospital; Doctor Frank P. Norbury of the Illinois Public Welfare Commission; and Major Frankwood E. Williams of the Surgeon General's Office, Washington. The object of the committee is to study the commitment laws of all the states and to suggest some standard forms for the observation, emergency commitment, temporary care and voluntary commitment of persons needing care and treatment because of mental disorder.

It has long been recognized that the commitment laws of many of the states are the expression of a misconception of the nature of mental disease. The individual suffering from mental disease is frequently treated like the lowest form of culprit. Under the guise of protecting his personal liberty, he is thrown into jails and lock-ups, and subjected to the humiliation of crowded court rooms. Happily, public sentiment on these methods is changing rapidly and commitment laws which will safeguard personal liberty and private property and at the same time insure the afflicted one adequate and scientific care and treatment, are now demanded, especially in the more progressive states.

The Committee on Legislation has submitted the following suggestions to the state authorities:

Observation and Care

If a person is found by two physicians qualified as examiners in insanity to be in such mental condition that his commitment to an institution for the insane is necessary for his proper care or observation, he may be committed by any judge or any other officer authorized to commit insane persons to any state, private or incorporated institution for the insane under such limitations as the judge may direct, pending the determination of his insanity.

Emergency Commitment

The superintendent or physician in charge of any institution public, private or incorporated, to which an insane person may be committed, may, without an order of a judge (or insert any other committing magistrate), receive into his custody and detain in such institution for not more than ten days, any person whose case is certified to be one of violent and dangerous insanity or of other emergency by two physicians, duly qualified as examiners in insanity, by a certificate conforming in all respects to the provision of law required in a medical certificate of insanity, and said certificate may, if the commitment of such person as insane shall be duly completed, be used as the certificate of insanity required by law. The officers required by the laws of commitment of the insane, or any member of the state or district police shall, upon the request of the applicant or of one of the said physicians, cause the delivery of such alleged insane person to such superintendent or physician. The person applying for such an admission shall within ten days cause the alleged insane person to be duly committed as insane or removed from the institution and, failing thereof, be liable to the institution for the expense incurred and to a penalty of fifty dollars which may be recovered by the institution by an action of contract.

Temporary Care

The superintendent or physician in charge of any institution public, private or incorporated, to which an insane person may be legally committed, may when requested by a physician, by a member of a Board of Health or by a health officer, by an authorized agent of the State Board of Insanity, by a police officer of a city or town or by a member of the state or district police, receive and care for as a patient in such institution for a period not exceeding ten days, (or fifteen days) any person who needs care and treatment because of his mental condition.

Such request for admission of a patient shall be in writing and filed at the institution at the time of the reception of the patient, or within twenty-four hours thereafter, together with a statement in a form prescribed or approved by the State Board of Insanity (or insert the proper title of the state supervising board) together with a statement giving such information as said board may deem appropriate.

Such patient who is deemed by the superintendent or physicians not suitable for such care shall, upon the request of the superintendent or physician, be removed forthwith from the institution by the person requesting his reception and, if he is not so removed, such person shall be liable for all reasonable expenses incurred under the provisions of this act on account of the patient, which may be recovered by the institution in an action of contract.

Said superintendent or physician shall cause every patient to be duly committed according to law, provided he shall not sign a request to remain as a voluntary patient, or to be removed therefrom before the expiration of said period of ten days.

All reasonable expense incurred for the examination of the patient, for his transportation to the institution and for his support therein, shall be allowed, certified and paid according to the laws providing for similar expenses in the commitment and support of the insane.

Voluntary Commitment

The superintendent or physician in charge of any institution public, private or incorporated to which an insane person may be committed, may receive and detain therein as a boarder and patient any person who is desirous of submitting himself to treatment, and who makes written application therefor, and whose mental condition in the opinion of the superintendent or physician in charge is such as to render him competent to make the application. Such superintendent or physician shall give immediate notice of the reception of such voluntary patient to the State Board of Insanity (or insert the proper title of the state supervising board).

Such patient shall not be detained for more than ten days after having given notice in writing of his intention or desire to leave the institution.

The charges for support of such voluntary patient shall be governed by the laws or rules applicable to the support of an insane person in such institution.

Community Service

Section 1. Every state institution, to which an insane, feebleminded, or epileptic person may be committed, shall appoint a physician experienced in the care and treatment of such persons, also the necessary assistants to such physician, and shall organize and administer under his direction a department for community service in the district served by the institution. The duties of said department shall be:

First: The supervision and assistance of patients who have left the institution with a view to their safe care at home, suitable employment and self-support under good working and living conditions, and prevention of their relapse and return to public dependency.

Second: Provision for informing and advising any indigent person, his relatives or friends and the representatives of any charitable agency, as to the mental condition of any indigent person, as to the prevention and treatment of such condition, as to the available institutions or other means of caring for the person so afflicted, and as to any other matter relating to the welfare of such person.

Third: Whenever it is deemed advisable the superintendent of the institution may cooperate with other state departments such as Health, Education, Charities, Penal, Probation, etc., to examine upon request and recommend suitable treatment and supervision for

A. Persons thought to be afflicted with mental or nervous disorder.

B. School children who are nervous, psychopathic, retarded, defective or incorrigible.

C. Children referred to the Department of Juvenile Courts.

Fourth: The acquisition and dissemination of knowledge of mental disease, feeblemindedness, epilepsy and allied conditions, with a view to promoting a better understanding and the most enlightened public sentiment and policy in such matters. In this work the department may cooperate with local authorities, schools and social agencies.

Section 2. The necessary expenses of said department shall be paid from a special appropriation for this purpose not exceeding ***** dollars, subject to the approval of the supervising state board or boards.

Conveying Patients to the Hospital

The judge or magistrate of the court may appoint a proper person to convey the patient to the hospital. If a woman is committed to an institution under the supervision of the state board or commission, the committing judge or magistrate must, unless she is accompanied by her father, husband, brother or son, designate a woman of reputable character and mature age to accompany her thereto.

Parole and Discharge of Patients

The superintendent of a state hospital may grant a parole to a patient under regulations prescribed by the state board or commission, for a period not exceeding one year, and may receive said patient again when returned by the proper authorities, relatives or friends, or upon personal application of the patient within this period without a new commitment.

A MODERN HOSPITAL

"The largest hospital in the world exclusively for Chinese is not in China, but in France," says the *American Journal of Public Health.* "The hospital is built for about 1,500 patients, but for emergencies has held 1,800. The chief of staff is Colonel Gray, formerly of the British Legation, Peking, who is assisted by 16 physicians and about 300 nurses and attendants." A description is then given of the modern construction and equipment of this hospital. In this description is found the following sentence: "*There is a detached area with high barbed wire entanglements and guarded for the insane* of whom there are 60, while another separate place is provided for lepers, of whom there are 16."

"This remarkable hospital," the *Journal* continues, "has the most modern equipment. There are medical and surgical wards and special wards for tuberculosis, influenza, trachoma, venereal and contagious cases and, in addition, an emergency ward. . . ."

HAWAII

John R. Galt, formerly President of the Associated Charities in Honolulu, has been appointed, by the Governor of Hawaii, Chairman of the Commission to Investigate Feeblemindedness in the Territory of Hawaii. The other members of the Commission are: Arthur L. Andrews, Secretary; William L. Whitney, Treasurer; Mrs. Charlotte D. I. Steere and Mrs. Rhode G. Thayer. The act creating the Commission appropriates $60,000 for the construction and maintenance of a home for the feebleminded, and specifies that this home is to be conducted on the farm colony plan, calling for the erection of suitable cottages or dormitories, schoolrooms, workshops, dining halls, kitchens, etc.

COMMUNITY HEALTH

Editorial, *The Detroit News.*

That private health is the public's business seems to be a growing conviction among those who give much thought to public welfare. Social workers, medical men, educators, and jurists make health the leading topic of discussion when they meet in convention or conference.

The misfortune of the physically defective child in school is not merely a matter of private interest. The public is affected because such a child requires increased attention from his teachers, gets poorer results, hinders the progress of his classmates, lowers averages, perhaps menaces the health of his associates and in many other ways lessens the efficiency of an institution supported at public expense.

And the community is interested in the health of the wage-earning population. A very large part of those who come to be a charge upon the public are thus reduced because of ill health. Poverty, destitution, public dependence are very largely public health problems fundamentally. Along with this then is involved the wide range of subjects such as housing, sanitation, recreation facilities, and even transportation.

These all relate to physical health, but there is recognized now as of vast public interest the subject of mental health. In New York a criminal sentenced to the electric chair manifests no interest in the date of his execution beyond a desire to hear returns from the coming prize fight. Doubtless society will find it expedient to put this man to death, but the time may come when we shall know that a mind which places so trivial a subjective value upon life and death is subject for psychopathic treatment rather than electrocution.

The conclusion from all this is that the importance of health in its broadest sense gives to public service a certain unity which is bound sooner or later to be recognized. It may well be that in Detroit we shall one day have institutional facilities which will train young men and women for public service having an intelligent insight at least into all the factors which make for public well-being. We may have courts which will cooperate with psychopathic institutions and some form of conference which will bring together in the public interest official and semi-official and unofficial workers dealing with social problems. In short that some sort of unified effort may be directed toward solving this one big problem confronting society. The signs of the times seem to point that way.

The One Supreme Task

Democracy, . . . enters but slowly into the current of human attitudes and habits of thought. Nevertheless in some fashion, however halting and obscure, it has ever been at work. For is not the very essence of civilization itself the attempt of man to modify his world, to construct something more congenial to his interests, real or fictitious, out of raw material which nature offers him? Invention is the gist of civilization. Each successive step in the long history has resulted from man's making over something, transforming that which he but finds, into a form in which it does not exist by nature, but only by art or artifice. Every step, then, is marked by the introduction of something new, which is the outcome of the transforming agency of human activity, and which would never have come into being if man had been content to accept and possess that which he merely finds. Consider briefly the two regions which exhibit such reconstructive activity, the physical things in outer nature, and the elements, instinct and what not, which man finds in human nature. The making of fire, of the bow and arrow, of pottery, the taming of animals, the smelting of iron—these are the epoch-making inventions which raise man through the successive steps of savagery and barbarism. Each is the discovery of a new art. But the discovery of an art is no mere appropriation or holding fast to some bit of nature; it is reconstruction of that which nature offers. And in one momentous invention or art, namely that of speech, and still more, in the use of graphic signs, it is the construction and the creation of something which nature of itself does not contain. That is, systems of ideas, embodied in language, made possible by speech and made permanent by writing, depend in some sense upon human activity. Instinctive sounds and meaningless marks are woven together, with the result that something new emerges. Significant ideas and a permanent language are the outcome of working raw material—sounds and marks—into a "finished product." And this process spells activity. It has become an all but universal habit of thought among us to define the progress of civilization in terms of technology and in the increase of man's control over nature. These successive steps by which early man invented something, made over some bit of nature's storehouse of raw material, are no doubt utterly sporadic, accidental, unconscious, compared with the persistent and deliberate adoption of the inventor's mental attitude in modern culture. We expect to make over and to control our world. "The key to modernity is control," says Shotwell. The democratic impulse to self-government, the view of the world as plastic and in flux, waiting to be made over into something which we desire, this attitude is all but lacking in primitive life, in the ancient world, in all cultures permeated by religion. There were practically no inventions in the ancient world; one wonders that an art so simple and elementary in principal as that of printing should not have been discovered by the Greeks. Apart from the absence of any necessity for the widespread diffusion of ideas, the reason lies in the fact that the Greeks did not look upon the objects in their world as raw material for human constructive and transforming activity. Their world was one to appropriate and to possess.

If civilization does however depend upon the inventive and transforming agency of men in respect to physical objects, it depends fully as much upon doing something with, reconstructing and transforming that which man finds within himself. This reconstruction of human nature is of greater significance than is the reconstruction of outer nature. Every law, every social institution, every form of government, every practical idea or ideal, is something made by man, introduced into the world of human instincts and passions and motives, and doing something to these elemental forces, which, left to themselves, they would not achieve. Something happens to human nature in the course of civilization just as something happens to trees and animals, grains and metals. We have hardly become habituated fully to the belief in our own power here; we still think and act as if, however we may succeed in making over physical nature, human nature is something which must be taken as we find it, and left with us as a static possession. These actual transformations and inventions in the arts of social life, the reconstruction and novelties in human nature, have been even more sporadic, more the result of blind necessity and of fortune, than those inventions which put us in partial control over the energies of nature. The democratic attitude and faith have been more slowly maturing here than there. There has not been as much in our prevailing philosophy and habits of thought to justify the hope of controlling and actively making over human motives and social structures, as there has been in the region of technology, machine industry, and physical processes. Yet it is inconceivable that the democratic attitude of activity and control should stop short of the world of human nature. It is precisely in this human region that men are sensible, as never before, of the imperious need for some conscious guidance and intelligent reconstruction, if any such thing be at all possible. The belief that it is within the bounds of possibility, and that it is the one supreme task to which enlightened men in all civilized communities should now devote every energy—this belief and the longing which it expresses, will without any doubt be one spiritual deposit left behind by the war. More than ever before shall we need a philosophy which shall envisage this hope and this attitude, interpret it, and relate it to some total view of man's vocation and his enterprise.—

George Plimpton Adams: *Idealism and the Modern Age.*

SCHOLARSHIP IN OCCUPATIONAL THERAPY

The Board of Directors of Montefiore Home and Hospital offers several working scholarships in occupational therapy at Teachers' College, New York City. The value of each scholarship is $350 and, together with certain instruction which is given at the Hospital, will cover the expense of training. The maximum time required for the work, including that at the College and at the Hospital, is sixteen months. This time includes three months of practical experience in hospital teaching and admits the student to recommendation for a Teachers' College certificate. Applicants who can give satisfactory evidence of having covered any part of the regular course of training may take advanced standing and so complete the work in less than twenty months. The extensive use in military hospitals of occupations for therapeutic purposes has made this a separate, though allied, profession from that of nursing, and the large need for this work in civil hospitals is gradually increasing the demand for teachers.

Information regarding the details of the course of study for teachers in occupations in hospitals may be had from the Department of Nursing and Health at Teachers' College, Columbia University, and applicants for scholarships should apply to the Director of Occupations, Montefiore Home, Gun Hill Road, East 210 Street, New York City.

A NEW ENDEAVOR IN PUBLIC HEALTH—A BUREAU OF MENTAL HYGIENE

Editorial, *Monthly Bulletin*, Department of Health, Newark, New Jersey, May, 1919

In 1908 the Board of Health of the City of Newark recognized the necessity of abolishing the practice of incarcerating mentally afflicted persons in police cells pending their examination and commitment to institutions. It was also seen that there was urgent need for the early care and treatment of such cases. To meet these conditions psychiatric wards were established in the City Hospital.

In 1907 a clinic for the treatment of nervous and mental diseases had been opened at the City Dispensary, also under the control of the Board.

The accumulated experience gained from the work done in both these institutions showed that the Department of Health was the logical center for the co-ordination of all activities pertaining to mental health. This belief now finds its expression in the establishment of a Bureau of

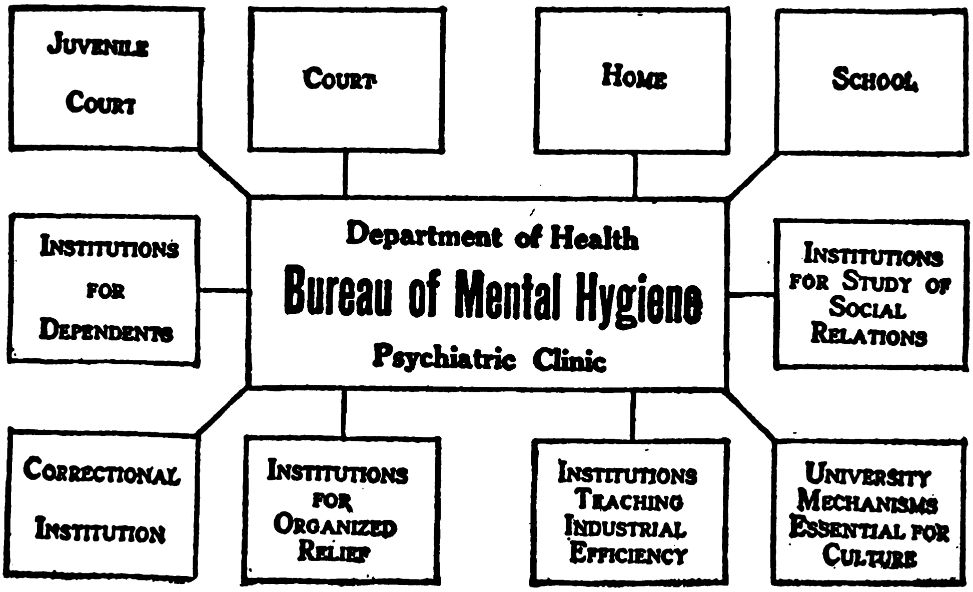
Mental Hygiene, which is, so far as ascertainable, a new endeavor in the field of public health service. The problems of mental hygiene properly belong to the sphere of organized public health work, and in fact they are so closely interwoven with its other activities that it is surprising such co-ordination was not brought about before.

The chart below, slightly adapted from the plans of Dr. Stewart Paton, who has done so much to encourage organized efforts to solve the problems of mental abnormality, gives a graphic outline of the scheme of work in which this Bureau will be engaged.

Among the activities of the Bureau will be the care and treatment of mental disorders and maladjustments of behavior, the examination of juvenile offenders referred by the Children's Court, the mental rehabilitation of the discharged soldiers, the examination of mental cases from the Child Hygiene and Venereal Disease Bureaus, the collection of statistics as to the number of feebleminded, epileptics and delinquents in the community, and the spreading of practical knowledge of preventive measures.

The present difficulty with regard to the proper handling of drug addicts is also one which appeals to the mental hygienist. The drug addict is essentially a mental case, and as such will be cared for through this Bureau, when appeal is made for the disposition of such cases,

Mental Hygiene, therefore, takes its place among the other public health projects by being finally recognized as a fundamental activity, which the City Health Department is required to carry on.


Juvenile Court
Court
Home
School
Institutions for Dependents
Department of Health
Bureau of Mental Hygiene
Psychiatric Clinic
Institutions for Study of Social Relations
Correctional Institution
Institutions for Organized Relief
Institutions Teaching Industrial Efficiency
University Mechanisms Essential for Culture

PUBLIC HEALTH SERVICE AND VENEREAL DISEASE CONTROL

Editorial, *Boston Medical and Surgical Journal.*

It is probable that few outside of the medical profession knew of the wide distribution of veneral diseases before our entrance into the world war. When, however, the examination of recruits from all over the country made it possible to collect data, the problem was found to be so great that concerted action on the part of all the citizens of the United States was called for. In order to make this possible, the Public Health Service cooperated with the state boards of health in establishing for the control of these diseases an organized campaign, with four principal objects in view.

First of all, it was considered necessary to secure the reporting of venereal infections in accordance with state laws or state boards of health regulations; second, that repressive measures be carried on, with isolation and treatment of infected persons in detention hospitals; third, that free clinics be established with proper facilities for early diagnosis and treatment of venereal diseases; and fourth, that a general educational plan be conducted to inform the public as well as infected individuals regarding the nature of these diseases and the way in which they are spread.

By the passing of the Chamberlain-Kahn bill, there was created on July 9, 1918, an Inter-departmental Social Hygiene Board and a Division of Venereal Disease in the United States Public Health Service. Among other things, this act provides for the allotment to state boards of health of one million dollars each year for two fiscal years, for use in controlling venereal disease. In order that the various states might be entitled to receive this sum, it was stipulated that they must agree to require the reporting of all venereal disease, to the assignment of an officer of the Public Health Service to the state to cooperate with the state health officer, to make available local or legislative funds, to extend educational measures, to secure additional legislation necessary for developing the control of the spread of venereal infections, and to expend the state allotment along general standard lines in accordance with a system to be advocated by the Inter-departmental Social Hygiene Board. The payment of the allotment for the year beginning July 1, 1919, is conditioned upon the expenditure of a like amount by the state. It is interesting to note that eighteen states have already had the necessary laws passed.

A recent public health report describes the duties and policy of the Division of Venereal Disease. It is specified by law that this department study and investigate the cause, treatment, and method of prevention of venereal diseases, cooperate with state boards of health in carrying on measures to prevent the spread of venereal infections, and promulgate and enforce interstate quarantine regulations governing the travel of venereally infected persons. It is gratifying to observe that in carrying out this program, the Public Health Service has been admirably supported. Druggists pledged themselves not only to discontinue the sale of venereal disease nostrums and to refuse to prescribe remedies for self-treatment, but also to distribute to sufferers circulars advising them to seek competent professional service; the response of the medical profession in reporting cases of venereal disease has been prompt; and the people as a whole have demonstrated their willingness to support the campaign against venereal disease.

THE EXCEPTIONAL CHILD IN THE PUBLIC SCHOOL

An exhibit and conference were held in May, in Osborne Hall, Yale University, dealing with the problem of the exceptional child in our public schools. An illustrated lecture, entitled "The Public School Care of Deficient Children," by Dr. Arnold Gesell, was given, followed by a conference including a group of fifteen-minute talks by Lieut. Arthur Otis, formerly Psychological Examiner, U. S. Army, Superintendent David Gibbs, of Meriden, Miss Nellie C. Smith, of Hartford, and Superintendent F. H. Beede, of New Haven. This conference was followed by a discussion of policy and possibilities by visiting school men.

An educational exhibit on the problem of exceptional school children was held at the Public Library. This exhibit included results of mental surveys in Connecticut, photographs and charts showing special class methods, specimens of handwork of special-class pupils, illustrations of methods of group testing used in the army, etc.

MANUAL OF MENTAL EXAMINATION OF ALIENS

Editorial, *U. S. Public Health Reports*

Those concerned with the problems presented by mental disease, and that should include health officers throughout the United States, will be interested in learning how the Public Health Service guards against the immigration of aliens suffering from mental disease or mental defect. The method of examination and the various procedures by which this undesirable class of prospective immigrants is excluded are well described in a *Manual of the Mental Examination of Aliens*, prepared under the direction of the Surgeon General and just published by the Public Health Service. Health officers will do well to ponder the following paragraph taken from this manual, summarizing as it does the chief reasons for regarding mental hygiene as an important public health activity:

Of all the serious problems in the field of public health activity, that of the mental examination of arriving aliens is one of the most important, and the detection of the insane and the mentally defective among arriving aliens and the prevention of their entry has a value that, from the standpoint of national welfare, can hardly be overestimated. Physical disability may give rise to dependency, but with the death of the individual the nation is relieved of the burden. In the case of the insane or mentally defective there is imposed a burden which tends to perpetuate itself. Each mental defective may become the progenitor of a line of paupers, vagrants, criminals, or insane persons which will terminate only with the extinction of the race. Were the expense to be purely financial it would be deplorable enough, but to the cost in dollars and cents must be added the ever-present moral degeneracy and its pernicious influence upon society.

The manual contains 112 pages and gives practical instruction to guide inexperienced medical officers in the application of their knowledge of mental disease and defects. Copies may be obtained by writing to the Surgeon General, United States Public Health Service, Washington, D. C.

THE TEACHING OF POLITICS IN AMERICAN UNIVERSITIES

Editorial, *The New Republic*

In no country in the world do the universities lay such emphasis upon the study of government as in America. No branch of the subject is left untouched. The eagerness with which new methods of administration, new systems of electoral procedure, new forms of commissions are added to the content of the curriculum is little short of amazing. The larger part of those who teach it are genuinely enthusiastic about their subject. Not a few of them are chosen to take a share in the actual process of government; and it is only fair to say that most of them are successful.

Yet the study of politics in America is in a curiously unsatisfactory condition. The student seems to accumulate an immense background of facts. Certainly, for instance, the average graduate of Harvard or Princeton or Columbia knows more about the forms of government than the average graduate of Oxford or Cambridge. He can tell you about commission government, or the referendum in Switzerland or county government in Massachusetts. But he cannot tell you what federalism means. He cannot explain the theory of sovereignty. He has few or no ideas upon the relation of state and government. For the most part, he knows little or nothing of the history of political ideas; it is difficult to convince him that politics has a history behind Rousseau. What he wants, broadly speaking, to know is the facts about Congress, the facts about the party system in England, the facts about the referendum. Behind those facts, to the principles they imply, he rarely seeks to penetrate.

The first main criticism touches the attitude to institutions. Every American student can tell you about the separation of powers; most of them are bewildered when you tell them that the separation of powers has broken down. Every student is clear that sovereignty means that the power of the state is supreme; but of John Chipman Gray's admirable dictum that "the real rules of a society are undiscoverable" they have no conception. No one can study the curriculum of the average American college without discovering why this is the case. We are studying forms without proceeding to the analysis of the substance behind those forms. We do not teach the student to grasp that "intuition more subtle than any articulate major premiss," which is the real stuff of which the state is made. In mechanical terms, our government is visualized as a purely static institution. Our knowledge, at least as we communicate it, is knowledge by description and not by acquaintance. We do not stop to explain why, for example, the committee-system of Congress has inevitably strengthened the executive by making discussion unreal and thus transferring the centre of dramatic interest to the solitary figure in the White House. We describe the boss system; but we do not explain the boss system as it originated from the over-simple Benthamite formulæ of the Jacksonian democracy. The result is that what we are exercising is less the student's mind than his memory. We are not teaching him to understand why a dogma like the separation of powers could arise, and why it is ultimately unworkable. We are not making him see politics as a living process made of the stuff of which our lives are woven.

We teach it, moreover, in isolation. That is, in part at least, not the fault of the instructor in government. The American college seems to believe that a student who does not, in his four years, learn a little art and chemistry and Spanish and corporate finance, has failed to receive the benefit of a wide education. The result is, of course, that his courses in government are at best but an item in a larger programme. They lack an environment that can give them complete purposiveness. The student can learn about the government of America and know nothing of the government of Europe. He can get a feeble smattering of international law and remain entirely ignorant of the history of political ideas. He is searching units for a degree and Professor Blank's course is reputed to be easy or interesting.

But the matter goes even deeper. You cannot study politics apart from history. You cannot understand the ideas of an age unless you understand the perspective in which that age is set. Cusa sets the background for Alexander Hamilton and the King's prerogative is the parent of the police power. We do not study politics in this way; or, if we do, we take a series of men and summarize their ideas without reference to the specific circumstances which evoked them. The undergraduate knows that the social contract is nonsense, but he does not grasp the fact that it is significant nonsense. But history is not enough. It is not necessary to accept the Marxian dogmas to realize that the economic institutions of the time are fundamental. A student of politics who is not also a student of economics is untutored in the essential relations of this subject. The great dictum of Harrington that power follows the distribution of property is a fact which finds little or no application in our teaching. Yet Acton could emphasize the impossibility of explaining political phenomena without its use. John Stuart Mill could use it as the explanation of the course of legislative progress in modern society. Everyone remembers the eager desire to overwhelm Professor Beard when he tried to show the influence of those myths proclaimed by every American thinker of ability since Madison and Hamilton. He may or may not have painted a picture out of perspective; but the elements upon which he insisted do not find anything like their full place in the interpretations we offer.

This aspect of our teaching is perhaps best illustrated by our failure adequately to emphasize the importance of psychological analysis. We are, after all, dealing with an eminently human set of facts; yet there are few teachers who emphasize the impossibility of understanding political phenomena without a thorough grasp of psychology. There are, indeed, few who do not know the change in perspective since Mr. Wallas drove the Benthamite psychology out of the political field. But, to take an obvious instance, we cannot explain the very fact of political obedience unless we are fully equipped with the latest knowledge psychology can offer. Do men obey, as Hobbes said, through fear? Is the real basis consent, as with Rousseau; or habit, as with Sir Henry Maine? The answer to this, and all kindred questions, we shall only know if we try fully to grasp and cautiously to apply the things we are being taught by men such as Freud and Jung, McDougall and the behaviorists. It ought to be understood that no student is equipped for serious political analysis except upon the basis of a thorough acquaintance with these studies.

There is also the question of books. It must be approached with hesitation because here, in some sort, is the head and centre of the whole question. We have innumerable volumes of description government. We have half a hundred introductions to political science. We have books full of "readings" which anthologize a subject lest the student be tempted to examine it too fully. What impresses a stranger to this country is the small use that is made of fundamental texts. The student reads the summary of Hobbes in Dunning or Janet, but he does not read the Leviathan. He reads Professor Gainer or Professor Gettell or Professor Leacock; but Mill and Rousseau, Aristotle and Locke, are, for most, too old to have real value. We do not use the ten or fifteen fundamental biographies in which the wisdom of a decade's experience is summed up in a single flashing retort—things like Morley's Gladstone, the letters of Acton, the correspondence of Hamilton or Peet or Bismarck. There, and there only, are the real secrets, the play of personality, the search for motives, revealed. We make little or no use of speeches; yet a student who reads, to take but a single instance, a day's debate on the Home Rule Bill of 1914 would know more of the pith of politics than is to be learned in a dozen textbooks.

OCCUPATIONAL THERAPY

Editorial, *Boston Medical and Surgical Journal*

Dr. Herbert J. Hall, of Marblehead, Massachusetts, in his article entitled "Bedside and Wheel-Chair Occupations," has summarized briefly the substance of a few of the lectures given to classes at the Boston School of Occupation Therapy. Some time ago the Surgeon General's office sanctioned the establishment of schools for the training of reconstruction aides,—women who should be at least 25 years of age, and of suitable personality, to furnish forms of bedside occupation and to direct the handwork of disabled soldiers. The course as outlined includes weaving, simple woodwork, basketry, block printing, knitting, applied design, a certain amount of practice teaching and hospital routine, and methods of invalid teaching. It is not required that the young women shall become expert craftsmen, nor shall they be expected to prepare the men for a trade. The object of these simple occupations is to exercise the mind as well as the body. Work, of a suitable nature, is the best possible means of restoring nerves and muscles to normal action.

Bedside and wheel-chair occupations are now a permanent factor in military hospitals and the result of this kind of therapy will be seen in the work produced by the men. Some patients will be naturally clever, others awkward. But it is not so much the quality which counts,—"the reward is in the trying,"—and it often happens that through this means a man will develop a decided understanding of color, form, etc., which will later become the nucleus of a larger crafts system and thus the teaching in his case will of a certainty be justified. The first ideas which suggest themselves to one's mind at the mention of the word "hospital" are medical and surgical treatment; but before long a third idea will present itself also, in connection with civilian as well as military hospitals, "rehabilitation."

It has been found in every-day life that mental attitudes react upon all functions and produce in some cases what we call fatigue. This condition is an important factor to be considered in the reconstruction hospital. The reconstruction aide, therefore, is taught that by a simple process of graded effort, regulated activity is to be encouraged. Keeping in mind this fact, the possibilities of the use of the small handicrafts are readily observed and the daily wave of strength and resistance is carefully taken into consideration with each patient. The time for bedside occupations will usually coincide with the hospital daily routine.

Unless favorable conditions for work exist, unless the patient be encouraged and made hopeful, no amount of striving will accomplish the desired result. This is especially true among patients handicapped by nervous exhaustion. The satisfactory accomplishment of some very simple task which may be assigned to him may be all that man needs as an inspiration for further effort. Everything is possible with hope and ambition for a foundation, and with those two comes a moral and physical reinstatement which is of inestimable worth. For this reason, the establishment of occupational therapy in civilian hospitals, asylums, and state institutions seems now almost inevitable after its successful employment in the military hospitals, and through this means we may expect many an inmate of a state hospital, the chronic invalid, and even the bored convalescent, to improve his mind and body.

Massachusetts Psychiatric Institute

The research laboratories heretofore established and now maintained at the Psychopathic Department of the Boston State Hospital, by the Massachusetts Commission on Mental Diseases, are hereby continued and shall hereafter be known as the Massachusetts State Psychiatric Institute. Such Institute shall be under the general supervision and control of the Massachusetts Commission on Mental Diseases, and shall be maintained by the Commission from appropriations obtained for the purpose.

The object of the Institute shall be:

1. To make psychiatric and pathological researches and investigations.
2. To give instruction in psychiatry, neurology, pathology, psychology, and social service, with special reference to instruction in the nature, causes, treatment and results of mental diseases and defects.
3. To promote the advancement of mental hygiene.
4. To encourage scientific work in the institutions.
5. To coordinate publications of a scientific nature.
6. To carry on the routine and special duties of the pathological service of the Commission.
7. To supervise and correlate the clinical and laboratory work of the institutions under the Commission.

For the purpose of clinical studies, scientific research and instruction, the clinical facilities of the institutions under the Massachusetts Commission on Mental Diseases, including the Psychopathic Department of the Boston State Hospital, shall be placed at the disposal of the Institute.

The Director of such Institute shall be psychiatrist to the Massachusetts Commission on Mental Diseases. He shall be appointed, together with such other officers and employees as may be deemed necessary, and their compensation shall be fixed, by the Commission. The Director shall perform, under the direction of the Commission, such duties relating to psychiatric and pathological research, and the instruction of medical staffs of the institutions under the Commission, and such other duties as may be required by the Commission. He shall have the supervision and control of such Institute and of the physicians and other employees therein, subject to the general direction, supervision and control of the Commission. The institutions under the Commission shall cooperate with the Institute in such manner as the Commission may, from time to time, direct. Such officers and employees as the Commission may determine shall, if required by the Commission, reside at the Psychopathic Department of the Boston State Hospital or such other institution as may be determined, and shall be furnished maintenance in whole or part.

Occupational and Industrial Therapy for the Insane

Editorial, *Boston Medical and Surgical Journal.*

The extension and improvement of occupational and industrial therapy in the treatment of the insane should receive more adequate attention. A pamphlet by L. Vernon Briggs, M. D., reviews the research work in this field which has been reported in medical literature, and surveys the occupational work being done in our schools and hospitals at the present time. It is interesting to observe the policy adopted toward the insane in the middle of the nineteenth century, as compared with the attitude which is taken toward this class of sufferers today. Then, such methods as the strait-waistcoat, the tranquillizing chair, the deprivation of customary pleasant food, and "the pouring of cold water under the coat so that it descended to the armpits" were some of the methods to which physicians resorted.

One physician of this time, however, disagreed with these modes of coercion and advocated bodily labor as one of the measures necessary for the moral treatment of the insane. Dr. Amariah Brigham, superintendent of the Utica Asylum, recommended that workshops where dressmaking, tailoring, basket-making and other industries could be taught should be connected with institutions. For some patients, he believed that mental training would be beneficial, and that reading, drawing, music, arithmetic, natural sciences, and other studies could be taught with good results. In 1847, he advanced his theories against the prevailing views on coercive treatment of the insane, saying that he believed that employment in order to benefit the patient should be for its own sake and separated from the idea of gain. He organized an asylum school, and introduced a great variety of occupational instruction; he established a whittling shop, a printing office, and other industries in connection with his institution. These schools were a part of the hospital routine.

The author of this pamphlet believes it probable that except for the addition of gymnastics and dancing, and the development of the more strictly artistic handicrafts, little has been devised in any state hospital in this country since Dr. Brigham's day for the diversion and occupation of patients. Would it not be advantageous, perhaps, to put these matters, still under medical direction, into the hands of educators trained in the knowledge of occupational therapeutics? Compared with the progress which has been made in the fields of therapeutic occupation for the blind, the crippled, and other handicapped individuals, therapeutic occupation for the mentally ill has not received the impetus which it should have received. A comparison of statistics covering the work of a purely therapeutic nature shows little increase in the past two years. Although ward and farm work have increased, this is probably due to economic reasons rather than therapeutic application of this work to individual needs.

In order to make it possible to have all the patients working, an adequate hospital force is one of the first requisites. In addition to expert teachers, a corps of instructors among the nurses, who had taken a course in therapeutic occupation in the training school, would be of valuable assistance in studying the needs of patients. A careful study made last year by the Massachusetts State Board of Insanity of the working capacities of the state institutions under their care shows that they had on June 1, 1916, a total of 17,683 patients, and that the working capacities of the institutions could have provided employment of some sort for 92.54 per cent of the patients. On that date, 72.66 per cent of all patients were reported as occupied. Of these, only 3.03 per cent were occupied in shops and 8.94 in industrial rooms, making a total of 11.97 per cent of the patients in scientifically directed branches of occupation under special trained teachers. Many of these patients work but a small part of the day.

The importance of occupational therapy is recognized, and a more thorough, systematic organization of occupational and industrial work and educational instruction would benefit the patients and contribute valuable material to scientific research.

SPECIAL TRAINING FOR TEACHING MENTAL DEFECTIVES

The state normal schools at Oswego and Geneseo, New York, are offering special summer courses for training teachers for mentally deficient children. These courses are the result of recent legislation making special classes mandatory in all communities in which there are ten or more children three years mentally retarded, in consequence of which there is a steadily increasing demand for special-class teachers.

The course at the Oswego State Normal School includes fundamentals of mental deficiency, mental testing of normal and subnormal children, and daily observation and practice teaching with a class of mental defectives. It aims to train teachers to become organizers and supervisors in the public schools of New York State. The Geneseo State Normal

School aims to give the practical training necessary for a beginning in special-class teaching. A course in abnormal psychology is included with case studies and observation in a nearby hospital. Both these normal schools are offering courses in wood working, industrial arts, household economics, folk dancing, rhythm work, plays and games, corrective gymnastics, methods in reading, numbers, story, music, etc. Lectures on mental deficiency are given, and also class discussion in the administration of special classes and kindred subjects.

NATIONAL CONFERENCE OF SOCIAL WORK

The National Conference of Social Work held its forty-sixth annual meeting at Atlantic City, June 1–8. The program was one of unusual interest. The Conference is composed of ten divisions under the following captions: (1) Children, (2) Delinquents and Correction, (3) Health, (4) Public Agencies and Public Institutions, (5) The Family, (6) Industrial and Economic Problems, (7) The Local Community, (8) Mental Hygiene, (9) Organization of Social Forces, (10) The Uniting of Native and Foreign Born in America.

The general theme of the Mental Hygiene Division was *Social Problems as the Reaction of Individual Mental Types to Environment.* The general session was devoted to the topic, *Difficulties of Adaptation as Revealed in Military Life*, the speakers being Col. Thomas W. Salmon, formerly Senior Consultant in Neuropsychiatry, American Expeditionary Forces, and Lieut.-Col. Frankwood E. Williams, Chairman of the Division.

The program of the various section meetings of the Division on Mental Hygiene follows:

1. *Methods and Results of Recent Investigations of Mental Defect*
    - Methods of Creating Public Interest in the Problem of the Feebleminded, Thomas H. Haines, M.D., Mississippi Mental Hygiene Commission, Jackson
    - Recent Advancement in Tennessee in the Care of the Insane and Feebleminded, C. C. Menzler, Executive Secretary, Department of State Charities, Nashville
    - Mental Hygiene Surveys in Canada, C. M. Hincks, M.D., Secretary and Associate Medical Director, The Canadian National Committee for Mental Hygiene, Toronto
2. *Psychiatric Social Work*
    - Place and Scope in Mental Hygiene, Miss Margherita Ryther, Chief of Social Service, Protestant Episcopal Hospital, Philadelphia
    - The Individual *versus* the Family as the Unit of Interest in Social Work, E. E. Southard, M.D., Director, Psychopathic Hospital, Boston

The Psychiatric Thread Running through all Social Case-Work, Mary C. Jarrett, Chief of Social Service, Psychopathic Hospital, Boston

3. *Training of the Psychiatric Social Worker*

Qualifications of the Psychiatric Social Worker, Jessie Taft, Ph.D., Director, Department of Child Study, Seybert Institution, Philadelphia

The Special Preparation of the Psychiatric Social Worker, Bernard Glueck, M.D., Mental Hygiene Department, New York School of Social Work

The Training School of Psychiatric Social Work at Smith College, Edith R. Spaulding, M.D., formerly Director, Psychopathic Laboratory, Women's Reformatory, Bedford Hills, New York

4. *Education and Mental Hygiene*

William H. Burnham, Ph.D., Professor of Pedagogy, Clark University, Worcester, Massachusetts

C. Macfie Campbell, M.D., Professor of Psychiatry, Johns Hopkins University, Baltimore

William A. White, M.D., Superintendent, St. Elizabeths Hospital, Washington, D. C.

5. *State Care of Mental Diseases and Social Work*

Function of the Social Worker in Relation to a State Program, George M. Kline, M.D., Director, Massachusetts Commission on Mental Diseases, Boston

Function of the Social Worker in Reference to the State Hospital Physician, H. Douglas Singer, M.D., Alienist, Department of Public Welfare of Illinois, and Professor of Psychiatry, University of Illinois

Function of the Social Worker in Relation to the Community, Miss V. M. MacDonald, Organizer of Social Work, The National Committee for Mental Hygiene, New York

6. *Disciplinary Problems*

Methods of State Procedure, V. V. Anderson, M.D., Psychiatrist in Charge of Special Work in Mental Deficiency, The National Committee for Mental Hygiene

Methods of Procedure in the Army, Herman M. Adler, M.D., Criminologist, Department of Public Welfare, State of Illinois

Methods of Procedure in the Navy, Lieutenant-Commander A. L. Jacoby, United States Naval Prison, Portsmouth, New Hampshire

In addition to the above meetings, a joint session with the Family Division was held on the topic, *Some Scientific Bases for Social Case-Work*, and a session on the *Causes of Delinquency*, with the Division on Delinquents and Corrections.

OUT-PATIENT CLINICS

The Massachusetts Society for Mental Hygiene has recently issued a valuable pamphlet containing a list of thirty-nine out-patient clinics in Massachusetts for the examination and treatment of patients with mental diseases or defect (Publication No. 36). The publication was prepared for the information and convenience of physicians, judges, school authorities, Red Cross workers, district nurses, social workers, and others, as well as for the growing number of voluntary patients seeking the aid of qualified experts. The publication of the list at this time is particularly opportune, as it will serve the interest of discharged soldiers, who may thus readily select a clinic near their home at which they can receive advice and treatment. The cities and towns in Massachusetts which have psychiatric clinics are listed alphabetically with the name of the clinic, the location, hours and information as to the special function of any particular clinic.

NATIONAL ASSOCIATION FOR THE STUDY OF EPILEPSY

The eighteenth annual meeting of the National Association for the Study of Epilepsy was held at the Craig Colony for Epileptics, Sonyea, New York, June 6 and 7. This Association was organized in 1901, for the purpose of promoting the pathologic, therapeutic, social and medico-legal study of the epilepsies. In 1912, the Association became affiliated with the *International Liga Contra l'Epilepsie*, which is the world association for the study of epilepsies.

The meeting in 1918 was not held because of the war, and reorganization and resumption of activities were effected at the 1919 meeting. The program set forth scientific medical, social, and institutional aspects. Clinics and demonstrations of régime were conducted by members of the medical staff of the Colony. Plans for a union of investigators in allied and neutral countries with those of America were discussed.

Members of the medical profession and laymen who are students of the various aspects of the epilepsies are eligible to membership.

AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION

The seventy-fifth annual meeting of the American Medico-Psychological Association was held in Philadelphia, June 18–20.

One session was devoted to administration and state problems, with the following speakers: George M. Kline, M.D., Director, Massachusetts Commission on Mental Diseases, Boston; H. Douglas Singer, M.D., State Alienist, Department of Public Welfare, Illinois; Burdette G. Lewis, Commissioner of Charities of New Jersey; Owen Copp, M.D., Superintendent, Pennsylvania Hospital, Department for Mental and

Nervous Diseases, Pennsylvania; James V. May, M.D., Superintendent, Boston State Hospital, Boston.

Another session included military papers by Dr. Thomas W. Salmon, Dr. Frankwood E. Williams, Dr. L. Vernon Briggs, Dr. Sanger Brown, 2nd, Dr. Edward A. Strecker, Dr. John H. W. Rhein, Dr. D. A. Thom, Dr. George E. McPherson and Dr. Tom A. Williams.

The session entitled *Reconstruction* was addressed by Dr. Pearce Bailey, Dr. George J. Wright, Dr. T. H. Weisenberg, Dr. V. V. Anderson and Dr. Frank P. Norbury.

Sessions were also devoted to statistics and classification, social psychiatry and criminology, laboratory papers and clinical psychiatry. Round-table conferences were held on the subjects of administration, military matters, scientific investigation, occupational therapy and nursing.

THE AMERICAN ASSOCIATION FOR THE STUDY OF THE FEEBLEMINDED

The forty-third annual session of the American Association for the Study of the Feebleminded was held in Chicago, May 28–29. A few of the titles on the program were as follows:

The Feebleminded and the War, George S. Bliss, M.D., Superintendent, Indiana School for Feebleminded Youth, Fort Wayne, Indiana.

Temperamental Variability in Feebleminded Delinquents, J. Harold Williams, Ph.D., Director of Research, Whittier State School, Whittier, California.

Are Morons the More Dangerous Defectives? J. B. Miner, Ph.D., Professor of Applied Psychology, Carnegie Institute of Technology, Pittsburgh, Pennsylvania.

The Problem of the Defective Delinquent, Guy G. Fernald, M.D., Director of Survey, Maine Commission on Provision for the Feebleminded, Augusta, Maine.

The Care of the Defective Delinquent, Colonel C. B. Adams, St. Charles, Illinois.

Delinquency in its Relation to Mental Defect, William Healy, M.D., Director, Judge Baker Foundation, Boston, Massachusetts.

Present Status, and Plans for the Future, of the Ohio Bureau of Juvenile Research, Henry Herbert Goddard, Ph.D., Director, Bureau of Juvenile Research, Ohio Board of Administration.

The Arrangement of Hypophrenias (Feeblemindedness) for Diagnosis Per Exclusioneum in Ordine, E. E. Southard, M.D., Department of Neuropathology, Harvard University, and Director of the Psychopathic Department of the Boston State Hospital, Boston, Massachusetts.

What Institutions for the Feebleminded Can Do for Returned Soldiers, Douglas A. Thom, M.D., Psychiatrist in Charge of War and Reconstruction Work, National Committee for Mental Hygiene, New York, N. Y.

Mental Defect as Seen in Juvenile Court, Judge Arnold, of the Juvenile Branch of the Circuit Court of Cook County.

Defective Delinquency, Major Herman M. Adler, M.C., Army Disciplinary Barracks, Fort Leavenworth, Kansas.

The Need of State Surveys in Presenting the Problems of the Feebleminded, Frank P. Norbury, M.D., Norbury Sanitarium, Jacksonville, Illinois.

A State Program for the Feebleminded, Walter E. Fernald, M.D., Superintendent, Massachusetts School for the Feebleminded, Waverley, Massachusetts.

Problems of the Feebleminded as Revealed by Systematic Examinations of Recruits and Army Experience, Lieut. Colonel Frankwood E. Williams, M.R.C., Associate Medical Director, National Committee for Mental Hygiene.

Rehabilitation of the Mentally Defective—Illustrated, Charles Bernstein, M.D., Superintendent, New York State Custodial Asylum, Rome, New York.

The officers elected by the Association for the ensuing year are as follows: George E. Bliss, M.D., Superintendent, Indiana School for Feebleminded Youth, Fort Wayne, Indiana, President; H. A. Haines, M.D., Superintendent, Michigan Home and Training School, LaPeer, Michigan, Vice-President; J. M. Murdoch, M.D., Superintendent, State Institution for the Feebleminded of Western Pennsylvania, Polk, Pennsylvania, Secretary; F. Kuhlman, M.D., Ph.D., Director of Research, Minnesota School for the Feebleminded and Colony for Epileptics, Faribault, Minnesota, Assistant Secretary and Treasurer. The Association passed a resolution "That the President of the Association appoint a committee of five on classification and uniform statistics and invite the cooperation of the Bureau of Uniform Statistics of The National Committee for Mental Hygiene." The president appointed the following committee: Walter E. Fernald, M.D., Waverley, Massachusetts; J. M. Murdoch, M.D., Polk, Pennsylvania; H. A. Haines, M.D., LaPeer, Michigan; F. Kuhlman, M.D., Faribault, Minnesota; George Mogridge, M.D., Glenwood, Iowa.

ABSTRACTS

Mental Defectives in Industry. By Ada M. Fitts. *Ungraded,* 4: 179–183, May 1919.

One of the serious problems confronting every school department is the education of the groups of mentally defective children found throughout the elementary grades. In regular class rooms they constitute a serious handicap both to the teachers and the normal child and, according to Dr. Terman, Professor of Education at Leland Stanford Junior University, this is equally true after they leave school and attempt to take their place in industry. He says:

"Industrial concerns doubtless suffer enormous losses from the employment of persons whose mental ability is not equal to the tasks they are expected to perform. The present methods of trying out new employees, transferring them to simpler and simpler jobs as their inefficiency becomes apparent, is wasteful and to a great extent unnecessary. A cheaper and more satisfactory method would be to employ a psychologist to examine applicants for positions and to weed out the unfit."

State after state is providing by law for the mental examination of all children who are three or more years intellectually retarded. Unimprovable cases are to be placed in institutions and those who are judged to be of an improvable type are to be placed in special classes, there to be trained so far as possible for the life that so many of them will live in the community. Many of this mentally defective group, if given intelligent training and supervision, will grow up to be useful to a limited degree and need be neither a public burden or menace. Our problem is to train them for the positions that they are able to fill.

The question arises, "Have they a place in industry?" and while I agree that they should never have positions of responsibility they may act as subordinates and help in doing much of the comparatively unskilled work of the world. A recent experiment would seem to prove that the high grade moron type has industrial efficiency. A California canning factory during a labor shortage needed workers to save tomatoes from spoiling and to complete government contracts. A neighboring school for defectives sent thirty-six inmates, under the care of a supervisor, to the cannery where for eighteen days they worked alongside normal adults. The defective girls worked with the incentive of saving food for the soldiers, of having the money earned to spend for something they wanted and they also had the stimulus of being put on a par with normal workers. The average daily wage for those who peeled tomatoes was $1.32 against $2.20 earned by normal workers. The moron packers earned $2.30 per day and the normal workers $3.75. From this it will be seen that the moron woman had an earning capacity of about 60 per cent of that of the normal woman. In this school both men and women were tried out in other forms of manual work and the 60 per cent efficiency held good. This would seem to indicate that their industrial efficiency may be made available if the right conditions are maintained.

The best results will, of course, be obtained when these children are selected at an early age, say seven years, and then grow up in the special class and there have all the academic, physical and manual training instruction of which they are capable, but the great cost of such training is often brought forward as an argument against such classes. We find a suggestion of help along this line from Dr. Wallin of St. Louis, who says:

"In order to reduce as far as possible the expense of special classes to the community, and in order to provide opportunities for the children in these classes to acquire the habit of doing things which have a direct utilitarian value both to themselves and society, a part of the manual training work should consist in making articles or supplies which are of use to the pupils themselves or to the schools; or which can be sold, the proceeds to revert to the special classes for the purchase of materials."

When they reach 12 or 13 years of age they need more advanced work which must be adapted to their needs. Those who have made a study of the situation and of the after careers of mentally defective pupils know that such children cannot be trained to enter skilled trades. A few of them may be trained to do excellent work but even these must have long-life supervision and constant direction in order to compete with normal workmen. In planning for vocational training for defectives it must be remembered that all that are left for them are the unskilled trades. Miss Anderson, Supervisor of Classes for Defectives, in Newark, N. J., in an excellent book, entitled *Education of Defectives in the Public Schools*, gives the following list of work which the feeble-minded have done in various communities.

1. Handy men around a place.
2. Dish washers in hotels.
3. Window cleaners for trolley or railroad companies.
4. Assistant janitors.
5. Cleaners in bakeries, butcher shops, etc.
6. Helpers for drivers on wagons.
7. Domestic servants.
8. Barbers' assistants.
9. Laundry workers.
10. Assistants to masons.
11. Assistants to carpenters.
12. Factory work which requires much repetition.
13. Errand boys for tailors.

14. Cobbling and shoe repairing.
15. Bootblacks.
16. Chair caners.

From our experience in Boston I would add messenger boys, workers in brush and candy factories, grocery boys and waitresses.

It is surprising that of the over twenty occupations listed only four are directly trained through shop work.

A school kitchen where the children help to prepare, serve and clean up after a meal, is of even greater service in providing training for the future. One of our so-called "centers," or schools where eight special classes are housed, provides over one hundred boys with a well-cooked, well-served noonday lunch. The pupils pay for the expense of material and do most of the work, always under the direction of an able teacher. In addition, they learn to care for food properly, wash the towels, assist the janitor in sweeping, cleaning, washing windows, care of sidewalks and yards, and removing ashes. These same boys of 14 to 16 years of age have made blouses, serving coats and caps, and have thoroughly enjoyed the sewing class, without the least feeling the work was unmanly. Three months ago they requested a sewing machine and were furnished one. Up to date it has been in constant use and but four needles have been broken, all of which have been replaced by the boys themselves and of their own initiative. Printing and bookbinding have also proved to be of great value to certain of this group.

Many of the boys have been truants of long standing but the new kind of a school appeals to them. One boy said when asked why he liked the school, "I like the 'eats,' the car tickets and the variety of work." Another, the son of an organ grinder, asked if he might make a dog blanket for his dog. When told "yes" he next brought two strings, showing the length and width of his pet. The help of his chum was secured and together they constructed a very satisfactory blanket and the final remark—to my mind a great compliment to his teacher—was "Nobody but you, Miss C———, would have let us do it." Would that we had more who understand boy nature and who can see the educational value of such attempts! These same boys are often sadly in need of repairs and recently a little colored boy asked if he might sew a patch on his trousers. His teacher, another of the right sort, offered to do the job for him, so the small boy was draped in a large piece of red and white gingham, and sat thus arrayed while the mending was being done. Apropos of the cooking, a boy who broke his leg was sent to the hospital. This message came back: "They haven't anything on us at school on 'eats.' We could give them points there."

In the girls' "centers," sewing, embroidery, millinery, cooking and all branches of house work should be carried on to the highest degree of which the children are capable. They too, should have the definite work that will train for good habits, deftness in manipulation and power to do things that will be useful to them in after life. We often fail to realize that these are our servant girl problems who, if properly trained, would become less difficult to handle.

One must not forget the distinct value of school gardens and farm instruction for this class. It is possible to establish in the vicinity of a city farm groups, which shall serve as training opportunities. There, the boys, under direction, are utilized to develop practically worthless land into soil ready for cultivation. As army training camps are given up it would be possible to use sites already equipped with buildings, water, sewers, etc., for the care and training of a great number of defectives. Under such conditions they would be removed from the temptations and competition of city life and have a share in doing a very important part of the world's work.

In shoe factories, candy factories and similar places, there are many departments where much of the work calls for little skill and much repetition. It is possible to get in touch with these employers, explain the limitations of our children, ask for suggestions as to the training which will help to prepare for such positions and then carry out these suggestions in the schoolroom. It is even possible to allow the child to leave school on condition that he go to work at a place chosen for him. If he does not make good he may return to school, and if it seems wise be tried again with another firm. There must be freedom to do the thing that is best for the individual.

It will be readily seen that along with intelligent training in special classes, "trade classes" or whatever one chooses to call the finishing school of this group, there should be constant and wise supervision. As has been said, "In the special class the pupil can be prepared for some appropriate employment but cannot be given self-direction. The normal person can guide his life as he will, but the subnormal, young or old, does not have that guiding power within. He may be made self-supporting if he has only someone to do the planning. His passions and powers need outside control which should never be relaxed. The need is for a person who will watch the career of each graduate and act as adviser, who will consult with employers, coöperate with court officials and institutions, and continue the guidance and control begun by the teachers." It is absolutely necessary to have an after-care teacher if the mentally defective child is to have a place in industry and keep it, if he is to be protected from moral and economic exploitation and safeguarded adequately. One such worker says:

"The attitude of parents toward the after-care worker has been strikingly interesting. After understanding that the visitor has come with the desire to help save and coöperate with them in solving a problem that colors the whole family life, the indifference and secretiveness disappear and unconsciously the inner life of this afflicted group is laid bare. To accomplish this end many visits may have to be made, for success follows only on patient, earnest work with one end in view, to give relief. Such work is only possible when there is close coöperation between the supervising and teaching force, in both regular and special departments, combined with social workers, probation officers and courts."

Besides the children that are plainly mentally defective we all come in touch with a group of borderline cases, often having serious behavior difficulties. Personally I feel that it is occasionally a good thing to use a special class as a clearing house and study such misfits. Here is the report on one of them.

A Syrian boy, nine years old, was admitted in order, if possible, to discover why he was not succeeding in the grades. It was found that, while he could do fair academic work for his age, he was handicapped by distinct language disability; his home conditions were most unsatisfactory; he went with a rough gang whose diversions were petty stealing, throwing stones at peddlers, and the like. He lacked accuracy, tired quickly, was often a truant, had a bad reputation with the police, and a court record with suspended sentence. He also had his good points, one of which was sharing his luncheon with a puppy. He liked the special class, established friendly relations with the teachers, the father was made to accept responsibility, and as there was no mother, was persuaded to pay twelve dollars a month that his boy might be placed in an industrial school, where the child is happy and is giving no trouble. All this was accomplished by the study of the problem and because there was a follow-up teacher to work out its solution.

We have allowed a large group of the mentally defective to grow up without proper training. We failed to recognize them while in school; they were not adjusted to life in the community; they became criminals and they fill our prisons. Of this group, the first report of the Psychiatric Clinic of Sing Sing Prison states: "The same inefficiency which characterized these individuals in their school and social contact is again reflected in their industrial careers. Out of ninety-eight cases, eighty-two or 83.7 per cent were unskilled laborers, while fifty-six or 57.1 per cent were unemployed. The industrial career in practically all of them was extremely irregular and inefficient, without goal or object of any kind in view." Is it not time to recognize the mentally defective while he is in school, adopt an educational policy adapted to his needs and do everything possible to prevent his becoming a criminal? Dr. Fernald of Waverly told me recently that with no immigrants coming to this country we must surely rely more and more on the defective group for our source of unskilled labor.

To me it seems that we have only just begun to work on this whole problem of "The Almosts" as Dr. MacMurchy calls them. We are feeling our way along; good work is being done here and there all over the country, but do we not need to pool our knowledge and resources, to get together and formulate the best plan of action?

GEOGRAPHICAL DISTRIBUTION OF DEMENTIA PRAECOX IN NEW YORK STATE. By HORATIO M. POLLOCK, PH. D. *State Hospital Quarterly* 4: 312–24, May 1919.

This is a study based on 9,024 dementia praecox patients admitted to the civil State hospitals from October 1, 1911, to June 30, 1918.

The data of general population of the State census of 1915, which was taken at approximately the mid-point of the period, were used for the computation of rates in counties, cities and villages. As the published census does not give the sex distribution of the general population of the State, rates by sex could not be computed.

The first statistical table presented shows the number of dementia praecox patients of each sex admitted from the urban and rural districts of each county of the State during the period, together with rates of totals per 100,000 of general population. Of the 9,024 dementia praecox patients, 3,563 were residents of New York county; 1,698, of Kings county; 222, of Queens county; 281, of Bronx county; and 68, of Richmond county, making a total of 5,832 patients, or 64.6 per cent, resident of Greater New York. Other counties contributing large numbers were: Erie 494, Monroe 355, Westchester 289, Albany 199, Onondaga 127, and Rensselaer 119.

The average rate of admission of new dementia praecox cases per 100,000 of general population of the State for the whole period of 6¾ years was 93.1. The average annual rate was 13.8. The general average rate in the urban districts of the State for the whole period was 106.7; on an annual basis it was 15.8. The general average rate for the rural districts of the State for the whole period was 40.4, and on an annual basis, 6.0. The rate in urban districts was therefore 2.3 times as high as the rate in rural districts.

Of the 9,024 dementia praecox patients, 4,694 were males and 4,330 females. Of the 8,189 patients admitted from urban districts 4,259 were males and 3,930 females; of the 814 patients admitted from rural districts 414 were males and 400 females.

The two sections of the State in which dementia praecox is most prevalent are the lower Hudson valley, including New York City, comprising the counties of Albany, Rensselaer, Columbia, Dutchess, Putnam, Westchester, Bronx, New York, Kings, Queens, and Richmond; and the lower Genesee valley, consisting of the counties of Monroe, Genesee and Livingston, together with the adjoining counties of Erie, Niagara and Orleans. From these 17 counties came 7,624, or 84.5 per cent of the 9,024 patients studied.

These two sections are similar in many respects. Both contain large cities; both have thickly populated rural districts which are closely related to the adjoining cities; both are easily accessible to immigrants and consequently a large part of their population is foreign born; both are centers of manufacturing and commerce.

The second statistical table shows the dementia praecox admissions, during the period covered, from each of the cities of the State together with the rate of admissions per 100,000 population. A summary of the table showing the admissions with rates from cities of the various classes, compared with the admissions from villages and rural districts, is given herewith:

DEMENTIA PRAECOX FIRST ADMISSIONS, 1912-1918

		Rate	
		per 100,000 of population	
	Number	*1912-1918*	*On annual basis*
First class cities, 175,000 and over	6,555	114.0	16.9
Second class cities, 50,000 to 175,000	576	90.9	13.5
Third class cities, 20,000 to 50,000	328	68.1	10.1
Third class cities, 10,000 to 20,000	304	77.8	11.5
Third class cities, under 10,000	90	49.6	7.3
Villages over 2,500	224	54.3	8.0
Rural districts	814	40.4	6.0

It will be observed that the highest rate is found in the first class cities, the next highest rate in second class cities and that the third class cities from 10,000 to 20,000 have a higher rate than the third class cities from 20,000 to 50,000.

Two hundred twenty-four dementia praecox patients were admitted from the 98 villages of the State having a population of 2,500 or over. The number of patients admitted from the individual villages is too small to furnish a safe basis for comparative rates. The general average rate per 100,000 of general population for all such villages grouped together is 54.3. It will be observed that the average rate in villages is lower than that of any of the groups of cities except the third class cities having a population of less than 10,000.

The author draws the following conclusions:

1. The rate of incidence of dementia praecox is much higher in cities than in rural districts.

2. The two sections of the State in which dementia praecox is most prevalent are the lower Hudson valley and the lower Genesee valley. These sections have several points of similarity.

3. The rate of incidence of dementia praecox is higher in large cities as a class than in small ones, but the individual exceptions to the rule seem to indicate that the size of the city is not the dominant factor.

The author states that in the absence of a definite knowledge of the etiology of dementia praecox, a full explanation of the variation in the rate of incidence of the disorder in the various counties and cities of the State cannot be made. The following possibilities, however, are deemed worthy of consideration:

1. Differences in diagnosis in the several State hospitals might cause variation in rate. The districts having the highest rate of incidence of

dementia praecox furnish patients for the Central Islip, Kings Park, Manhattan, Hudson River and Rochester State Hospitals. So far as known, the attitude of the staffs of these hospitals toward the diagnosis of dementia praecox does not differ from that of the staffs of the other State hospitals, and as the matter of uniform diagnosis has been emphasized throughout the State hospital system during the past ten years, it is quite unlikely that any differences in diagnosis now existent constitute an appreciable factor in causing variation in rate.

2. It is much more probable that the rate of incidence of dementia praecox is influenced by the race distribution of the general population. It is well known that there is a high rate of dementia praecox among Hebrews and Slavs and a comparatively low rate among the Celtic and mixed races. The high rate of incidence of dementia praecox in Manhattan Borough may possibly be accounted for by the high percentage of Slavs and Hebrews in the general population. Unfortunately the race distribution of the population of the State is not available.

3. The complicated life of the city may influence the rate of admission of dementia praecox cases by making it difficult for mild cases to remain at large in the community or to be cared for at home. It is probable also that mild cases of dementia praecox receive less attention in the country than in the city, with the result that a smaller proportion of the cases arising in the country are admitted to State hospitals.

4. If it is assumed that dementia praecox is a hereditary malady, the presence in any locality of a considerable number of families bearing the taint of the disorder would have a decided influence upon the rate in the smaller cities and towns.

THE CORRELATION OF NEUROLOGY, PSYCHIATRY, PSYCHOLOGY AND GENERAL MEDICINE AS SCIENTIFIC AIDS TO INDUSTRIAL EFFICIENCY. By JAU DON BALL, M.D. *American Journal of Insanity*, 75:521–55, April 1919.

In the introduction the author speaks briefly of the problem of organized labor, the industrial unrest of today, and the breach between capital and labor. He advocates a closer "relationship between employer and employee and the stabilization of industries by the application of scientific and practical selection of the human material at hand; and the stabilization of the individual by being interested in him, thus creating trust, confidence and cooperation, as well as driving home the principles of good fellowship. To do this, it is absolutely necessary to study the individual as regards his *physical*, *nervous*, and *mental* fitness for a particular job, and to ascertain his special abilities and disabilities."

This article represents a study of a number of industrial plants, among which was one of the large ship-building plants on the Pacific coast. The study included personal interviews with managers, superintendents, foremen and men, study of individuals, and methods of employment used at the plants and at United States employment offices. The author was particularly impressed with the fact that the efficiency of every plant is entirely dependent upon methods used in its employment bureau. Capital and labor must come to realize the great necessity for the *proper selection and distribution of labor.*

The examinations employed included (1) general medical, (2) neurological, (3) psychiatrical, (4) psychological and (5) social. The proper coordination of all scientific aids in industrial examinations is urged, without which, together with a rational interpretation of results, erroneous conclusions are likely to bedrawn. "For example, an individual might have a so-called normal intelligence and by psychologists be classed as a capable individual, yet a neurological or psychiatrical examination might reveal a serious pathological nervous or mental condition, making such a person a potentially dangerous individual for any industry; or the medical examination might reveal incipient or advanced pulmonary tuberculosis, active syphilis, or some abnormal physical condition or defect, making the individual a menace to his co-workers and a danger to himself. All this, notwithstanding that he possesses normal or above average intelligence, and by psychological tests alone would be passed, demonstrates the great necessity for proper coordination of all scientific aids in industrial examinations."

The general medical examination is outlined as follows: (1) general appearance, (2) vision, (3) hearing, (4) heart, (5) lungs, (6) skin, (7) teeth, (8) venereal diseases, (9) surgical diseases, (10) condition of blood and urine. Under the neurological examination are found the following headings: (1) principal deep and superficial reflexes, (2) station, (3) tremors, (4) neuro-circulatory syndrome and (5) speech disturbances. The psychiatrical examination includes direct observation and the preparation of a questionnaire, suggested form for which is included in the article. This questionnaire embraces (1) family history, (2) health history, (3) personal history, (4) social history, (5) education, (6) industrial history, (7) reaction toward present environment, (8) special abilities and (9) nervous and mental phenomena which would indicate further examination. The tests used in the psychological examination were furnished by Dr. A. Warren Stearns, recently of the neuropsychiatric division of the United States Navy, and include the following: (1) Trabue test, (2) disarranged sentences test, (3) cancellation test, (4) auditory memory test, and (5) visual memory test. These tests are described in detail on pages 530 to 534 of the article.

The following individual vocational chart was designed by the author and when filled in presents a clear picture of the employee to his superintendent or foreman. The Roman numerals are explained as follows: I, Very superior, II, Superior, III, Above average, IV, Average, V, Below average, VI, Inferior, VII, Very inferior. The top row of letters are to be interpreted thus: A, Education, B, Intelligence, C, Physical, D, Nervous, E, Mental, F, Vision, G, Attention, H, Continuity of effort, I, Follow directions, J, Speed, K, Accuracy, L, Trustworthy, M, Social, N, Apperception, O, Opinion of foreman, P, Special abilities—(1) learning, (2) planning, (3) assembling and discrimination, (4) analytical with manipulating, (5) reporting (inspection).

No.... Sex.... Age.... Wage.... M. S. W. D.... Occupation....
Organisation ....
Plant..
Department ....
Examiner...

															P				
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	1	2	3	4	5
I	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
II	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
III	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
IV	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
V	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
VI	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
VII	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

Personality .... Recommendations:
Character..
Habits ....
Traits { Desirable
Undesirable
References...
Labor { Especially Skilled
Skilled
Experienced
Unskilled
Employed as......................

A form is also suggested to be used in reporting to an industrial organization a survey of its plant from a medico-psychological standpoint. Special individual cases with their charts are found at the end of the article. There is also included a form arranged for the Marchant Calculating Company, of Oakland, California, to enable foremen to describe a particular job. Some interesting data with reference to 57 strikers at this plant are also presented.

In conclusion, the author advocates, as an economic asset and desirable, the establishment of medico-psychological laboratories as the principal department of employment bureaus of every large industrial organization, and suggests the establishment of a central employment clearing house with medico-psychological laboratory which would act for groups of industrial organizations too small to conduct their own bureaus economically. A representative of labor organizations should be in each of these bureaus. The author outlines the ways in which scientific selection and distribution of labor would react to the benefit of the individual, the industrial organizations, the labor organizations and the community. He also suggests (1) the working out and adoption of some system for the proper selection and distribution of labor which will ultimately become standardized for all occupations; (2) the avoidance of the confusion of the work of efficiency experts with medico-psychological work; (3) the application of the scheme outlined in this paper to all industrial organizations, public and private, including banks, department stores, and public service corporations; (4) the establishment of medico-psychological laboratories in connection with public schools, which would be of great value to the vocational guidance bureaus of municipalities, save much industrial inefficiency, be of service from the standpoint of prophylactic criminology, and be of value to industrial organizations, labor organizations and probation courts.

THE FOURTH GREAT PLAGUE—DEFECTIVES. By MARIAN K. CLARK. *Modern Medicine*, 1:143–49, June 1919.

Attention is called at the beginning of this article to the fallacy that "all men are born equal." Mrs. Clark says in this connection, "There can be no equality either of opportunity or of competition in a struggle for existence between the fit and the unfit; between the offspring of the sane and the insane; the normal and the feebleminded; the moral and the criminal; the employable and the unemployable; or the tainted and the untainted, with all of their immeasurable dissimilarities and ever increasing disabilities."

The author, who is Chief Investigator, Bureau of Industries and Immigration, New York State Industrial Commission, states that "the object of this paper will be to discuss the immigration problem from the standpoint of the established relationship of the immigrant to heredity, as well as to point out that through the admission of excludable alien stock an inequitable burden of unfit defective and criminal dependents is created.

"The new immigration law excludes persons who have had one or more attacks of insanity at any time previous to landing, as well as persons of constitutional psychopathic inferiority, and chronic alcoholics. The law is also broadened to exclude mental and physical defectives irrespective of their financial condition or ability to earn a living. The enforcement of these provisions will have a far reaching effect provided that the law itself is not abrogated by the issuance of 'rules and regulations' permitting these excluded classes to land under bond in the discretion of the Commissioner General of Immigration, or with the approval of the Secretary of Labor; but even this grant of discretion does not warrant the acceptance of a bond for an idiot, an epileptic, or members of other classes definitely and finally excluded by the terms of Section 3 of the Immigration Law."

Mention is made of the staggering financial burden imposed upon the State of New York, as well as the great social problem, on account of the admission of excludable aliens through the medium of inequitable and unenforcible bonds. The federal government has the authority to admit while at the same time it disclaims responsibility for the maintenance of the insane, feebleminded, diseased, etc., after they are released from Ellis Island. The State of New York annually receives for permanent residence one third of the immigrants to this country, and an average of two thirds of all excludable aliens admitted. Data are presented to show the result of suspended deportations from August 1, 1914 to July 1, 1917—a total of 3,923 excludable aliens, of whom 1,723 were insane, 2,005 excludable from other causes as liable to become public charges, and 195 suffering from infectious diseases.

Reference is made to a census study made by The National Committee for Mental Hygiene, on January 1, 1917, of institutions caring for the insane, feebleminded, epileptics and inebriates,* and data are quoted from this report. Among other facts, the study shows that whereas the population of the United States increased 11.8 per cent from April 15, 1910, to January 1, 1917, the number of insane in institutions increased during the same period from 187,791 to 234,055—24.6 per cent.

"It has been conclusively demonstrated that the feebleminded child will remain feebleminded. . . . If we are to retain our national stability an amendment must be read into the immigration laws of this country, providing for the mandatory exclusion of all unfit and defective aliens, and to assure the survival of the fittest, the expeditious deportation of all of those who have become dependents within the five-year period. . . . Far better an illiterate, able-bodied alien whom we can instruct at little cost in time and money, than a defective whose traits will be transmitted to posterity."

The author refers to the Jukes, the Nam family, the "Ishmaelites" of Indiana, the Owen family of Kentucky, and gives other examples to show the results of consanguineous matings of defective strains, and further states:

"Extreme examples such as the above are necessary to drive these incontrovertible facts into the public consciousness and to illustrate the utter recklessness of permitting the admission into this country of feebleminded, epileptic, insane, and imbecile immigrants who, together with their progeny, eventually reach the hospitals, almshouses, and prisons of the state.

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* A similar, but more comprehensive, study of these institutions was made by The National Committee for Mental Hygiene in 1918. Cf. Pollock, Horatio M., and Furbush, Edith M. Annual census of the insane, feebleminded epileptics and inebriates in institutions in the United States, January 1, 1918. *Mental Hygiene*, v. 3, no. 1, p. 78-107, January, 1919.

"The fact that the number of feebleminded in the country greatly exceeds the number of insane, as well as the fact that there are fewer of this class of defectives in institutions in every state of the Union, but accentuates the danger from a eugenic point of view."

During a low decade of immigration—from 1890 to 1900—while the population of the State of New York increased 21.2 per cent, the prison population decreased 6.5 per cent; whereas from 1900 to 1910, the decade of highest immigration in the past 99 years, the prison population increased 37.6 per cent while the general population increased 25.4 per cent.

"The cost of maintenance of alien prisoners in the State of New York amounts to over a quarter of a million dollars each year; but of exceedingly greater importance is the cost of the propagation of these criminal strains when released. It is certain that many convicts were defectives at the time of admission and should have been arbitrarily excluded from the country. In many instances aliens have committed crimes within twenty-four hours after their arrival."

Figures are presented which show that over 40 per cent of the prison population of New York in the years 1910, 1914 and 1917 were foreign born.

". . . . Owing to the fact that the new stock has been proved to be more prolific than the old, it is clear that the balance of political power will soon be in the hands of the children of foreign-born parents or foreign extraction. All of this argues against the vesting of discretionary power with respect to the admission of unfit and excludable aliens in any single official, instead of in a commission empowered to exclude on purely scientific tests.

"The United States is harboring a foreign population of 15,000,000 immigrants plus their 19,000,000 children—irrefutable evidence of the fecundity of the strains introduced through immigration channels and comprising altogether one third of our total national population. Are they to gravitate into the debit or credit column of the nation? If that prolific blood is tainted, it follows that it will most assuredly become a liability of no mean proportions; but if on the contrary it transmits virility, as a nation we can count the invasion of the immigrant as a huge and ever-growing asset."

The total alien registration in our army during the war was 1,243,801. Correspondence between them and their friends and relatives was carried on in 43 different languages.

In New York state, in its 60,000 factories, 2,000,000 workers are employed, of whom approximately 1,600,000 are foreign born. Seventy per cent of those presenting claims for industrial accidents in New York state require the services of an interpreter.

The author would encourage the immigration of mentally and physically sound foreigners to replace the hundreds of thousands who have become maimed or have withdrawn from industry through accidents and the estimated 5,000,000 who are planning to return to Europe. She believes that America for the next century at least should be Europe's workshop and the producer for the world. The gap must not be filled with insane, feebleminded, or syphilitic stock.

"Bitter are the casualties of war, but of a bitterness far more intense are the casualities of peace—industrial accidents, preventable disease, carelessness, crime, ignorance, and the violation of Nature's most fundamental laws. The victims of these contingencies create an army of the unfit with nerves as shattered and diseases as incurable as any of those whose sacrifice has been necessarily offered in the service of their country. Some of these evils we must have, but the deliberate and indeed iniquitous introduction of the unfit into the commonwealth is unnecessary and unjust to both our native and foreign-born population, and should be forever prevented by the most drastic legislation."

THE WOUNDED IN MIND. BY Thomas W. Salmon, M. D., recently Colonel, M. C., U. S. A. *Carry On*, 1: 3–6, July, 1919.

In the neuro-psychiatric ward of one of the large army general hospitals is a young soldier from overseas who wears no wound chevron on his right sleeve although the arm covered by it ends at the wrist. He is sad and rarely speaks unless spoken to. If the medical visitor asks how he came to lose his hand he moves his lips without answering. If the question is repeated he replies, with much difficulty in framing the words, that he would rather not say. When pressed in a kindly manner he hesitatingly makes this statement, shame and sorrow mingling in his face: "Well, sir, it was this way. I was in the Argonne forest. I was scared—and homesick—and I blew my hand off with a hand grenade." Unless the visitor has special knowledge of mental diseases and reads the lesson of the sad demeanor and retarded speech he is apt to think that this is only a glimpse of one of the darker sides of war. If, however, inquiry is made into the history of this patient it is discovered that he was courageously engaged in a charge against a machine gun position when his hand was blown off by the bursting of a shell which killed several of his comrades. The young soldier suffers from a rather common and fortunately extremely recoverable type of mental disease known technically as manic-depressive psychosis because it has phases of excitement and depression that often alternate. The sadness that constitutes the central symptom of the phase of the disease from which this soldier suffers is accompanied by thoughts and delusions in harmony with his emotional mood. Soon, with proper treatment, a change will come about and then if the patient's surroundings are what they should be and his awakening interests skillfully utilized, he will get well. Then his wound will no longer serve only as a point about which to group delusions of unworthiness characteristic of his disease.

In another hospital there is a lieutenant who won the Distinguished Service Cross. It would be interesting to quote in full the account of the deed for which this award was made but, so strikingly did it stand out in the column of citations in which it appeared in the newspapers, to do so would be more than likely to disclose the patient's identity. This young officer is suffering from the same mental disease as the man with the amputated hand and he is prevented by his distressing delusions of unworthiness from accepting the medal that he won on the field of battle. Fortunately he too will recover and the award which now only intensifies morbid feelings of self-deprecation will become a source of pleasure and pride.

In another hospital is a soldier whose brain was pierced by a fragment of bursting shell. Entering his skull, this tiny missile followed a course determined by the innumerable chances that govern the progress and arrest of an object in flight. Had it rested finally in a certain locality it could have been easily extracted through one of the skillful procedures of modern neurological surgery. Had it lodged in another place or passed through different structures it would have given rise to blindness, to local and unimportant paralysis, to paralysis of the entire side of the body, or to alteration of one of the special senses. A combination of certain factors in physics, ballistics, fate, and anatomy of the human central nervous system led to the lodgment of this piece of enemy steel where its presence and the processes that it set up resulted in grave changes in the young soldier's personality and thus he became a "mental case." A bright and sunny nature changed to one in which suspicion and irritability predominated. Memory commenced to show slow impairment and as, unfortunately, there are no surgical or other means of relief the outlook for this soldier is a slow darkening of the mind which in the end will cut him off from communication with this world and those in it whom he loves. He lost his mind to help us win the war. Throughout his life the minds of others must do for him what his own cannot.

The stories of these three soldiers are taken almost at random from those of 3,000 men with mental diseases (some recoverable and some not) who have been returned from the A. E. F. What are we doing for men suffering from invisible wounds such as these?

Thanks to the mental examination of recruits in the camps in the United States, the rate for mental diseases in the A. E. F. was the lowest in the history of any expeditionary force. This means, for one thing, that the task of caring for the soldiers who came back to us with mental diseases is not *numerically* a formidable one. There are as many new cases of mental disease admitted every year to the Boston Psychopathic Hospital, where they receive skillful individualized treatment, as have been returned from France.

From the earliest period of preparation for war the Surgeon General of the Army has stood strongly upon the principle that the resources at his disposal were for the benefit of the mentally ill as well as those afflicted with other illnesses or the injured. The ignorant and cruel idea that if the brain happens to be the seat of disease or injury the patient is outside the fields of medicine and nursing found no place in the army's conception of duty. When the base hospitals at cantonments were built neuro-psychiatric wards of the most modern design were provided. Through these wards, staffed by specialists in this branch of medicine and by nurses and enlisted men who had received training in the care of mental and nervous cases, passed no less than 30,000 soldiers with mental illness. In these cases the problem faced was a relatively simple one for many of the patients had had mental disease before their admission to the army and it was desirable after a period of emergency care to place them in the hands of their friends or in suitable hospitals in their own states.

A different problem was presented by mental cases among the soldiers returning from France. These, it must be borne in mind, originated among a highly picked body of men and it is apparent not only from this fact but from the symptoms that many of them present that the disease is due or is aggravated by the conditions of active warfare. The hospitals of the army of occupation had hardly been established before psychiatric wards were in active operation at Coblenz and Treves and physicians, women nurses, and occupation instructors were ready to receive mental cases. In the various "collecting stations" and in the big special neuro-psychiatric hospital at Savenay, every attempt was made to continue treatment and encourage a healthful attitude toward their disease in the soldiers awaiting transportation to the United States. At home psychiatric departments have been provided in all large general and base hospitals receiving overseas cases. Special wards and in one instance a special hospital have been provided at ports of debarkation. With the closing of larger general hospitals it was found advisable to concentrate the care of overseas soldiers in one large psychiatric hospital—General Hospital No. 43, Hampton, Virginia. Here in the National Soldiers' Home that has been taken over entirely there is being developed under the hands of some of the best trained men in this branch of medicine a modern hospital for the treatment of mental diseases, with all that that implies. Patients arriving at Newport News are admitted within a few hours after their ship has dropped anchor, and those arriving at the Port of New York reach Hampton within a day or two.

Careful examinations to determine not only the type of disease but the precise situation that has brought it into existence, attention to physical requirements, psycho-therapy, the use of occupation and diversion with special reference to the needs of individuals and outlining future care including vocational education all form part of the work of this institution. More important than any of these, except perhaps scientific diagnosis, is the spirit of understanding, sympathy, and hopefulness which officers and men alike are attempting to create in every room and ward of this great special hospital. Restraint, confinement in rooms, the employment of bars, idleness, or any other factor which will tend to degrade or humiliate patients whose illness happens to be in a field little understood and so often wrongly judged is not permitted to find a place in this hospital.

Many of the mental cases now being received have nearly recovered in France and will entirely recover at General Hospital No. 43. Just how large this percentage is cannot be determined but it seems likely that more than half of all patients admitted can be discharged, after a period of treatment, to their own homes. A close liaison has been established with the U. S. Public Health Service for the continued care of others. This medical service of the government is to provide the hospitalization to which the War Risk Insurance Act entitles each discharged soldier requiring it. The Public Health Service has made arrangements with those state hospitals that reach a sufficiently high standard of excellence in the various states to provide continued care for uncured cases at the expense of the government. Rigid inspection will make it possible to supervise this care.

It is necessary that everyone to whose attention such cases may come should bring them to the notice of the nearest representative of the United States Public Health Service. In most instances this can be done through the agency of the American Red Cross which is undertaking to provide after-care and psychiatric social service for men already discharged from the military service. Unfortunately a curious survival of the old feeling that mental diseases in some way carry with them a stigma unknown in other types of disorders often leads the relatives of patients and others to refrain from seeking treatment for them. In many other instances the situation and its remedy are obscured by applying the term "shell shock" to mental diseases. Those who fall into either of these errors fail in their duty toward patients whose own judgment is often incapable of securing for them the treatment they urgently need, and who, therefore, are dependent upon the judgment of others. "Shell shock," as is now becoming pretty well known, is a term correctly applied to only a very small percentage of the abnormal nervous conditions arising in battle. It was used very little in the A. E. F. after the first few months, the names of the various neuroses being employed instead to designate the functional nervous diseases of war. It may seem to the mother or wife of a soldier with mental disease that something is gained by substituting this term for one which properly describes the mental illness from which the patient suffers. There are even physicians who from mistaken kindness have encouraged this form of self-deception. It should not take much reflection, however, to convince one that such an evasion is apt to be extremely harmful to the patient by deferring the kind of treatment that he so urgently requires and giving rise in the end to disappointment and chagrin. The functional nervous diseases which in the A. E. F. were called "war neuroses" constitute quite a different problem in military medicine and reconstruction.

Its difficulties have not caused the army to evade the problem of the soldier with mental disease. If the community, his friends and relatives and the soldier himself contribute the kind of aid needed and maintain the proper attitude it will not be said of this war as it could well be of others that the most serious kind of diseases received the least efficient care.

BOOK REVIEWS

MORALE AND ITS ENEMIES. By William Ernest Hocking. New Haven: Yale University Press; London: Humphrey Milford-Oxford University Press, 1918. 200 p.

Hocking's book on Morale is a rare combination of morale in itself and ethical technique. One does not ordinarily expect much uplift from a professional moralist, except perhaps in the long run and after the big ideas are transformed in lesser minds. At all events the Aristotelian moralists do not strike one as uplifting. Hocking had the advantage of European experience devoted to the set purpose of analyzing the morale situation and enjoyed special opportunities, owing to the courtesy of the foreign offices of Great Britain and France. He dedicates his book to the young officers of the A. E. F. "who as chief builders of the morale of a great army do much to shape that of the nation for years to come."

Morale Hocking defines as the practical virtue of the will to war. Readers may be familiar with some of the chapters from the *Atlantic Monthly* and the *Yale Review*, as well as from certain theses published in *The Infantry Journal* in 1918.

The book is divided into two great parts, the foundation of morale, and the morale of the fighting man. From the standpoint of the mental hygienist, probably chapters III and IV of the first part on the foundations of morale in instincts and feelings and in knowledge and belief are of the greatest value. "The fighting instinct is coupled with another, the instinct of the herd." "Pugnacity is probably developed by nature originally as a mobile reserve for coming to the aid of other instincts when in difficulty." "There is in some persons a 'threshold of profanity' which marks the fact that the reserves are beginning to arrive." "The intrinsic weakness of affective morale, as psychologists call it, is that it puts both sides on the same mental and moral footing: it either justifies our opponents as well as ourselves, or it makes both sides the creatures of irrational emotion."

Major Eltinge's book, *The Psychology of War*, is criticized somewhat unfavorably as going far "toward reducing the enemies' cause and our own to the same moral status, thus destroying the morale of both army and people at its roots." Of course, as Hocking says, Major Eltinge had no such intention. "He was simply misled by the glamour of a 'crowd psychology' which has had many true things to say about human nature; but which is so far from giving the whole truth that it leaves wholly out of view the central nerve of all earnest and long range action,—conviction, the reasoned belief of thinking men."

Briefly put, Hocking's view would seem to be that of the Socratic idea that virtue is knowledge. Thus his work runs counter to some modern tendencies drawn largely (in the reviewer's opinion from mistaken interpretations of the Darwinian hypothesis) to the effect that the real bottom of the human situation lies in instinct. This view which Hocking did a great deal to counteract in his previous work *Human Nature and its Remaking*, Yale University Press, 1918, is subject to the fallacy of identifying the indispensable (instincts) with the essential (rationalization).

Just as Hocking attacks the mechanicalism of raw applications of "crowd psychology" to the military situation, so he has something important to say about discipline and drill. The book of Major-General W. A. Pew, *Making a Soldier*, is favorably quoted. This general calls attention to the drawbacks of the old Prussian model, according to which soldiers should be machines. The old Prussian model is contrasted favorably with the West Point model. The West Point idea of subordination, according to this author, is "not the unintelligent response of a machine, but the loyal support of an active mind which grasps the purpose of a commander and strives to advance it with force and energy."

There is an interesting chapter on *War and Women* and an endeavor to show why the soldier in general and the woman in general are in war time unusually interesting to each other. It becomes part of the soldier's problem that women are affected by the same unrest that characterizes the soldier. The German method of meeting the moral laxity problem is stated to be hygienically successful, yet the moral prophylaxis is rather more dubious. "It is a fair question whether there is not a direct causal connection between this measure [scientific prophylaxis against venereal disease] and the coarsening of fibre implied in the incomparable animality of the German armies in the field." If we administer prophylaxis preventing venereal disease, do we not acknowledge "the customariness of the breach of custom involved?" "The psychological step from this to the appearance of official sanction is a short one." Accordingly, we ought perhaps to counteract the impression of sanction in some positive way. According to some estimates, the number of professional prostitutes is smaller than the number of "amateurs" of London and of Paris. The value of putting the right sort of women into the canteen service, within and outside the war zone, is stressed. "The thing we have gone out to fight is a form of cynicism,—cynicism accepted as a philosophy of life and with a great army behind it."

E. E. SOUTHARD.

THE HIGH SCHOOL AGE. By Irving King. Indianapolis: The Bobbs-Merrill Company, 1914. 233 p. Childhood and Youth Series.

In this book the author discusses the problems of the high school period, laying the stress, where it should be laid, upon the individual and the complex factors which go to make up the total personality.

He begins by showing how much waste there is in the high school, many children not being there who should be there, many dropping out after one or two years. "For twenty years there has been no increase in the percentage of pupils who have graduated."

The author takes up the physiological and psychological characteristics of the adolescent period and discusses with much insight their relationship to the high school opportunities. The high school must stimulate the adolescent who must feel that it is worth while to devote himself to the studies offered. It is a period of self-assertion, of vague longing, of developing social impulses, of vague ideals and high aspirations. These are factors which cannot be ignored if suitable training is to be offered during the high school period. There must be contact with the individual pupil, and the great opportunity for moral training and character formation must not be lost. The personality of the teacher will be a factor of the greatest importance.

The economic background of the lives of the pupils, their social interest, their habits of study and their amusements are all discussed in a suggestive way in the later chapters of the book.

It is satisfactory to find a book dealing with educational problems having such a sound outlook on the wider problems of the individual school child. C. Macfie Campbell.

Rest, Suggestion, and Other Therapeutic Measures in Nervous and Mental Diseases. By Francis X. Dercum, M.D. Philadelphia: P. Blakiston's Son and Company, 1917. 2nd edition. 395 p.

This book consists of three parts. Part I, comprising the first six chapters, is devoted mainly to neurasthenia, hysteria, hypochondria, and, in a general way, to some other nervous diseases. Part II contains two chapters on the prevention and treatment of insanity. Part III takes up the subject of suggestion in two chapters, the first dealing with "normal" or "legitimate" suggestion, the second with methods which the author describes only to condemn. This last chapter is entitled, *Suggestion by Mystic and Religious Methods; Suggestion under Artificially Induced Hysteria-Hypnotism; Psychoanalysis.* It deals with "Pythonism, Shamanism, Magnetism, Mesmerism, Hypnotism, Psychoanalysis, Metallotherapy, Perkins's Tractors, Mind Cure, Faith Cure, Eddyism." The author's attitude in relation to these methods is stated in the introductory paragraph:

> "In a book like the present, a discussion of the subjects of this chapter is—so far as its direct teaching is concerned—somewhat out of place. The procedures employed certainly do not constitute physiologic methods of treatment. On the contrary, they usually call into being, as there will be no difficulty in pointing out, nervous states that are both abnormal and pathologic. However, because of the necessity of placing in bold contrast mystic and religious methods of treatment with physiologic procedures, the following sections have been appended."

An extreme, perhaps constitutional, conservatism seems to be the guiding principle throughout. Thus the nature of neurasthenia is defined as follows:

> "The exercise of function is synonymous with the expenditure of energy and the consumption of tissue; it is evident, therefore, that the means of reconstruction of tissue is to be sought for in rest and in food. Nature determines these factors for herself when the consumption of tissue has been physiologic. It is otherwise when the consumption of tissue has been abnormal. In the demands that modern civilization makes upon the individual, the undue expenditure of energy that results in overfatigue is of frequent occurrence. As a result, a condition is established in which neither physiologic rest nor food suffice any longer to restore the organism to the equilibrium observed in health. Gradually a well-defined neurosis with a definite symptomatology becomes established, and this is widely known among the laity as 'nervous prostration' and among physicians as *neurasthenia*."

In regard to hysteria, Babinski's viewpoint is the one adopted by the author:

> "If the physician test a healthy or normal individual for hemianesthesia, making at the same time free use of suggestion both direct and indirect, he invariably fails to develop the symptom. In other words, the normal individual repels, the hysteric individual accepts the suggestion. It is this vulnerability to suggestion which is the most striking feature of hysteria."

The student will not gain from the perusal of this book an insight into the modern conception of the nature of hysteria. No indication is to be found anywhere that special motives and mental mechanisms underlie hysterical conduct, save a brief reference to the *hysteria of litigants* claiming compensation, which is

> "provoked not by trauma, not by fright, but is the direct result of the psychology of compensation; namely, of the recognition by the plaintiff that the success of his claim for compensation depends upon the existence and persistence of symptoms. For this reason treatment, no matter of what character, is without avail. . . . However, all medical attendance ceases with the settlement. The symptoms disappear, the plaintiff forgetting all about them. The immediate absence of the plaintiff from physicians' offices and hospital clinics, the moment the money has been paid him, is one of the notorious and striking facts of compensation hysteria."

A shrewd practicality, evidently borne of abundant experience, is to be noted in the advice given by Dercum concerning the application of psychotherapy in hysteria:

> "This measure plays a large rôle in the successful treatment of hysteria. Indeed, without it the most elaborate rest methods may fail. . . . The physician should not be too aggressive with his suggestions, especially in the beginning. Indeed, his attitude should be that of accepting the illness and symptoms of the patient as a matter of course. The mere institution of rest and the various physiological procedures are a proof to the patient of the sincerity of the physician. It is only after the treatment has been established and has been under way for some time that the physician should begin a really serious psychotherapy. He should never be in a hurry to begin. The mistake may be beyond remedy, at least, so far as *he, individually,* is concerned. Time must be allowed for the patient to 'settle down,' *i. e.*, to adapt herself to her new environment, her nurse and her physician. Very soon the luxuriousness and exquisite physical comfort of a properly instituted rest treatment makes its impression upon the patient. As the days go by, the physician and the patient gradually become better acquainted. The nurse, too, learns

the little personal peculiarities of her patient, all of which she faithfully communicates to the physician. Very soon opportunities occur for more lengthy conversations, and the physician, being now thoroughly *en rapport* with his patient and having fully gained her confidence, can venture to make free use of suggestion. Indirect suggestion, we will say, has been employed from the beginning, but direct suggestion, explanatory and logical in form, can now be employed with great effectiveness. Sometimes the conversations with the patient reveal the way in which this or that special symptom arose, and this clue may be of value in its subsequent disposal; the physician may point out the inadequacy of the cause alleged and at the same time 'explain away' the symptom."

A. J. ROSANOFF.

MENTAL DISEASES. By Walter Vose Gulick. St. Louis: C. V. Mosby Company, 1918. 142 p.

This little book would merit no review were it not that the prevailing ignorance concerning psychiatry might lead some to purchase it, attracted by its interesting pictures. As a matter of fact there is nothing in the book of value to doctor or layman. The order of presentation is original in a curious sense; the meager clinical descriptions would never enable any student to recognize the clinical types; and the social ramifications of psychiatry are entirely ignored.

Here is a book which names *eight* symptoms as important in psychiatry, viz: ataxia, delusion, hallucination, illusion, orientation, pressure of activity, psychomotor activity and, to crown all, psychosis! The only mention of any treatment in the article devoted to general paresis is the Byrnes' intradural mercury method (shade of Ehrlich!). *Six* pages are devoted to feeblemindedness and constitutional psychopathic inferiority and of these *five are given over to irrelevant pictures.* The only bibliography in the entire book is a reference to a paper by Doctor M. Allen Starr on Shell Shock—in *Scribner's Magazine.* A. MYERSON.

THE DON QUIXOTE OF PSYCHIATRY. By Victor Robinson. New York: Historico-Medical Press, 1919. 339 p.

Progress at times seems to be made very slowly. One grows impatient that obvious needs are not met, that information at hand and ready is not put to use: that laws created in the middle of the last century and based upon the misconceptions of the time, remain; that institutions that should be hospitals continue asylums, and poor ones; that patients who should be cared for by nurses are waited upon by attendants; that medical students who as physicians will come in contact almost daily with mental problems remain untaught; that patients are denied treatment until their condition has passed the most hopeful stage. But the world does move. No further evidence is needed than the description of conditions at the Cook County (Illinois) Asylum in the chapter of this book entitled *Medicine Under King Mike.*

King Mike is the political boss of Cook County,—Michael McDonald, a proprietor of a saloon. And Mike rules Cook County and the Asylum is a part of his domain. The Superintendent of the Asylum is one Dr.

J. C. Spray, but the "Warden" is one Harry Varnell, the proprietor of a gambling saloon and a ward heeler, who at the point of a revolver enforces the edict, "I don't propose that any man who eats bread and butter under me shall vote any other ticket." The County Commissioners who had charge of this American medical institution in 1883 were "John Hannigan, the saloon-keeper; Mike Wassermann, who ran such a notorious resort under the Brevoort that it was closed by the police; Dan Wren, the skilful forger, recently out of jail; Mike McCarthy, the ex-stevedore, who found politics more profitable than his former job; Buck McCarthy, the drunken terror of the stockyards district, a strong animal who won elections with his fists."

An applicant for the position of pathologist who had been recommended by several eminent physicians of the city, and who had favorably impressed Dr. Spray, the superintendent, was invited one day to "come along with me and see if you can pass muster." To the applicant's astonishment he was brought to a drinking saloon on Clark Street. "The proprietor, an ordinary looking fellow, was leaning on the customer's side of the long counter. Spray went over to him and whispered, 'This is the doctor I was telling you about.' At these words the saloon-keeper raised himself, looked at the applicant for a moment, nodded quietly, and put out one finger for him to shake. 'I congratulate you,' smiled Spray to the applicant. It seemed like a joke, yet they were in a serious place. . . . It was King Mike whose nod had made him Special Pathologist to the Cook County Insane Asylum; had Mike turned away from him, all the recommendations of all the physicians in Chicago would have availed him nothing."

Thugs recently released from jail were sent to the asylum as attendants and so secure was their position that they openly insulted and flouted the superintendent and assaulted physicians who came to the rescue of patients being grossly abused. High revels were held by the politicians and their friends in the institution on Saturday nights. "The asylum was the ideal place for such revels, for it contained expensive Turkish and Russian baths . . . and it became the regulation thing for politicians to sleep off their debauches in the bath-rooms, being massaged to soberness by the county rubbers, for which the people seemed to pay cheerfully, as it was not proper that the County Commissioners should be drunk too long." A request to the warden for permission to purchase five or ten dollars worth of needed drugs was refused but the following week the management purchased $1500 worth of whiskey, wine and cigars—charged as sundry drugs—for the Saturday night revel.

Dr. Delia Howe had the honor of being appointed the first woman physician to serve in a public hospital in this country, but her career was brief and stormy. Although insulted by the women attendants and on one occasion felled to the floor by one of them she stuck to her post. Dr. Howe objected to the food being served to patients. The chief article of diet was pigs' heads, "hair and dirt and all—brought to the table unshaved and unclean." A particularly disgusting head having been served Dr. Howe retained a part of it to exhibit to the Commissioners. "When the relic was exhibited to the Commissioners, Mike Wassermann queried, 'What did you expect to find—gold watches?' But the other Commissioners viewed the situation with more perspicuity, and accordingly decided: Whereas, it is unseemly that iron rings should be found in pig-snouts, and Whereas, precautions must be taken against the recurrence of such an accident, Resolved, that no more lady physicians be employed at the asylum. Exit, Dr. Howe."

No records were kept at the asylum. An overly-enthusiastic physician began making records of his patients and soon became impressed with the fact that if patients of different types could be separated the chance of recovery for some would be greatly improved. He approached the warden for permission and got this reply: "To hell with the damned cranks. They are cattle to me, and I don't give a damn for them and am here for boodle. I'm going to make a pile out of the bughouse and start a big sporting place in the city."

The "Don Quixote of Psychiatry" is Dr. S. V. Clevenger. Dr. Clevenger did not begin the study of medicine until he was forty years of age. Following the Civil War he went to the Northwest where he worked for many years as a surveyor, but disgusted finally with graft and politicians he gave up his work and came to Chicago to study medicine. It was he whom King Mike appointed the first pathologist to the Cook County Asylum. It was he who, running away from politicians, ran into politicians of a worse breed. It was he who defied Harry Varnell and exposed in a Chicago paper the conditions at the Asylum. The contest that resulted was a long, hard and dangerous one but the county ring was eventually broken up, some of the commissioners fleeing the country, others going to jail. Later Dr. Clevenger had a somewhat similar experience, although not so violent, as Superintendent of the Kankakee State Hospital. Thus began the career of the Don Quixote of Psychiatry.

From this point on the story of Dr. Clevenger's life is woven into the story of the development of neuro-pathology and allied sciences in this country since the early eighties. Clevenger, aggressive, imaginative, enthusiastic, gave promise of accomplishment. But his interests remained too facile; continued application seemed impossible for him. Dash at windmills he did and his jousting was not always unproductive although he never made the contribution that his friends hoped he might. Joseph Leidy, the senior Spitzka, Harrison Allen, Edward D. Cope, William Pepper, Roswell Park were his friends and their work is discussed in connection with Clevenger. While the name of Clevenger cannot be placed beside those of his friends or beside that of George Huntington who described hereditary chorea, William A. Hammond who described athetosis, Segiun who investigated spastic paraplegia, the senior Spitzka who described the marginal tract of the spinal cord and others who have made contributions to neurology and psychiatry in America it can be placed with those who have fought for the rights of others too weak to fight for themselves.

There are few dull moments in *The Don Quixote of Psychiatry*. The book will be of particular interest to the younger psychiatrists to whom the chapter on King Mike will be a revelation and the more or less intimate discussion of the personality of men whose work has been so recently finished as not yet to figure in books of medical history will be new.

FRANKWOOD E. WILLIAMS.

PSYCHOLOGY AND THE DAY'S WORK; A STUDY IN THE APPLICATION OF PSYCHOLOGY TO DAILY LIFE. By Edgar James Swift. New York: Charles Scribner's Sons, 1919. 388 p.

To one familiar with the writings of Professor Swift this book will be an added pleasure and profit. To those unacquainted with this brilliant exponent of modern efficiency based on real applied psychology there is a fertile field awaiting them in which they may find "acres of diamonds" of sound scientific thought presented in unique style. The wealth of material presented in ten chapters covers a wide range of facts reinforced by experiments, anecdote and deductions from experience, all of which serve to clinch scientific arguments which point the way to practical success "in a day's work." His study of human behavior—"the individual's way of dealing with situations"—is approached from the standpoint of adjustments made in accordance with the accepted doctrines which modern physiological psychology teaches. The mental mechanisms utilized in the "strategy and tactics of life under the average daily experience of the individual" determine not only his capacity to achieve but give him his place as a social being. It is the understanding of these mechanisms which gives insight as to capacity—enables the round peg to find the round hole instead of the square one, and likewise creates and determines the social status of the individual. These two primary essentials make for success in the every day life of the individual. Deviations from the paths of the ordinary or average achievement of an individual lay the foundation for psycho-pathological conditions which interfere with thinking, feeling and doing and call for intelligent interpretation of these problems in human conduct.

Swift in popular entertaining style has covered the "psychology and the day's work" in such a way that the value of the book is enhanced both for the professional and lay reader. The book should be recommended to the adolescent facing the future in struggles for success; to the high school, preparatory and college teachers who need just such a practical book to supply facts in the fundamental problems with which they are confronted in the classroom and as counselors to the student body; to the employers of young men and young women who need a working knowledge of applied psychology that they may understand better selective service based on personality, efficiency and service.

The book is valuable, serviceable and worth while in every particular.

F. P. NORBURY.

THE THIRD GREAT PLAGUE. By John H. Stokes, M.D. Philadelphia: W. B. Saunders and Company, 1917. 204 p.

There has long been need for a book such as this but probably the need was never so great as at present. Venereal disease and military efficiency were incompatible. As a result venereal disease was controlled in the army and navy as it has never been controlled before in history. To bring about this control the cooperation of civil communities was necessary and to bring about this cooperation old taboos had to go and knowledge be substituted. As a result of the campaigns against venereal disease carried on in the American cities during the war there are few who do not have some knowledge of these diseases and there must be many who desire a fuller knowledge than could be obtained from the very valuable but necessarily brief discussions that were circulated by the government and other agencies. This book is for them. The text is simply written, is unencumbered with unnecessary technical phrases, while at the same time accuracy of statement is not sacrificed. Although written forcefully there is no attempt at exaggeration. And withal the book is hopeful. The book contains a brief history of syphilis, a discussion of syphilis as a social problem, the nature and course of syphilis, various tests for syphilis, the treatment and cure of syphilis, hereditary syphilis and the transmission and hygiene of syphilis. Not the least valuable are the chapters on mental attitudes in their relation to syphilis, moral and personal prophylaxis and public efforts against syphilis. It is to be hoped that this book will have wide circulation. It is a most valuable contribution to the popular discussion of the subject and can be recommended without reserve.

FRANKWOOD E. WILLIAMS.

THE DAWN OF MIND; AN INTRODUCTION TO CHILD PSYCHOLOGY. By Margaret Drummond. London: Edward Arnold. New York: Longmans, Green and Co. 179 p.

This book is printed without date, but apparently contains no reference to the literature after 1916. It does not pretend to incorporate or to summarize in any systematic manner the results of previous studies in child psychology, and can scarcely be regarded as a textbook. The contents are pretty much limited to the author's notes on the development of her own little niece (Margaret), with free reference and quotation from the published accounts of Miss Shinn and Preyer. There are chapters on early consciousness, memory and imagination, sympathy, reasoning and language, of which the discussion of the development of imagination is perhaps the most contributive in nature. The author's views on children's language do not seem to take sufficient account of the primary importance of native intelligence in determining the size of vocabulary. The author's treatment of her subject is sketchy, but it is concrete; and there are practical comments and suggestions in the field of mental hygiene. The emphasis on the hygienic and educational importance of the years from birth to six is timely. The book will probably be of most service as a brief introduction for parents, nurses and teachers. ARNOLD GESELL.

SUGGESTIONS OF MODERN SCIENCE CONCERNING EDUCATION. By Herbert S. Jennings, John B. Watson, Adolf Meyer, William I. Thomas. New York: The Macmillan Company, 1918. 211 p.

Books that promise more than this are rare. The specialist is always the best judge of detail in his own field, but not always in matters of larger policy. Most valuable criticism may be expected from distinguished colleagues in somewhat allied fields, as is offered in the present volume.

The book consists of addresses with immediate appeal to the generally cultivated audience. The aim is not so much to describe what education should be, as to inculcate active desire for improvement. Skilled hands wear very velvet gloves. Under the conditions of these addresses, *plus fait douceur que violence*, perhaps. But many a reader will miss from its pages the pen of a John Wallace Baird.

The papers have marked individuality that insists on their separate discussion. Jennings begins by comparing the biologist's methods of study with those of observing the child. Greater freedom for development of individual capabilities is sought, not only as a conception of education, but of democracy itself. Variety must be preserved; the serious consequences must be guarded against of training in a discipline unsuited for the degree of development. There must be no illusions of disharmony between physical and mental powers. Malnutrition is viewed from a suggestive angle; some popular misconceptions on hygiene are corrected. The question of heredity is given a very optimistic turn. Values of play are described and emphasized. Ill effects of schooling are quoted, well supporting the remark that "there is so much in education that looks like an attempt to undo" the purposes of nature. Professor Jennings' contribution has the most literary quality of the addresses. Statistical method would rate it high in "Charm," "Clearness," "Finish," "Sympathy" and "Wholesomeness." It is admirably suited to its purpose.

Watson's address is in large part a scientific contribution to be closely observed by colleagues who have not followed this work through other channels. It illustrates some practical workings of the behavior concept. Special work is described on the infantile grasping reflex and on stimuli in this period evoking fear, rage, and "joy or love." The original situations bringing out these reactions are studied, and the influence of the conditioned reflex mechanism in extending them. The educational implications of this are very great. The earliest years of life are valued in the same order as by psychoanalysis. It is hoped that the idea of an "experimental nursery" for further study of these problems can be worked out.

Greater plasticity in age is indicated than previously supposed, notably by James. "Any one of us who cares to put on the highly skillful acts needed in either work or play can do so provided he is willing to spend approximately a third more time than a youth would have to spend in acquiring the same acts." Data on comparative psychology are introduced in support of other fundamental conclusions on habit formation. Practise distributed over longer times is generally better than practise distributed over shorter times. (This is different from the problem of acquiring a certain skill in minimum time.) Practical suggestion here concerns the use of "odd minutes." The question of mutually conflicting or facilitating habits is also raised. The influence of incentive in habit formation is described, with the suggestion that the school can learn both from the laboratory and from business procedure in this respect. But in the present status of the school curriculum, the value of incentive to harder work upon it is problematical.

Meyer directs attention to the broadening of psychiatric influence, as it contributes to recognizing essential unity in the problem of health, and to better methods for studying the personality for practical management. Not the least service of viewing mind as an adaptive mechanism is the sense of proportion it brings between essentials and incidentals of life; e. g. the relation between action and knowledge. The thought of pp. 113–115 concerning language has probably never been so well put. Other passages may be here quoted. "Most diseases are chargeable to the unwillingness or inability to face realities of makeup and situation and to shape one's life in keeping with them." "It is with the utmost satisfaction that we note the recent progress toward individualizing education and the cultivation of the child's real assets." "Such a feature as clearness and correctness of thinking and expression belongs to nature study as well as to the lesson in grammar, and the accuracy, or lack of it, that prevails in the pupil's home and social atmosphere, ultimately decides how much grammar and accuracy of language can be expected at school."

Administrative relations of the school physician are discussed, and detailed account is given of the successful experimental work at Locust Point. This is a concrete illustration of value in principles on which the writers mainly agree; as by more time in supervised play and less time in more efficient study.

First reading of this address left the reviewer with less distinct impressions than did the other contributions. Meyer's work and pupils are witness to the worth of Meyer's ideas, but it is no secret that his writing is not always easily grasped. The presentation is also in considerable detail to follow rapidly. One can count on a wealth in reserve, and the study of this address does not soon reach the point of diminishing returns.

The remarks of Professor Thomas attempt too much. While indicating standpoints with which the reviewer is in close accord, they result in the least satisfactory contribution to the series. Topics in evolution of thought, folkways, crowd and individual psychology, education policies, rival each other in the genial manner attributed to the discourse of *Mr. Nupkins*. There is more anecdote than in the others, and some well turned phrases; the primary group norms, the distinctions of philistine, bohemian and creative, the social disharmonies from rapid mechanical progress, are conceptions of a high order of usefulness. There is the most direct allusion to the question of the classics. Reform lies along the path of the natural sciences (cf. Meyer above). The value of the ideas presented is modified by the flighty and sensational manner of expression.

Kitchener when asked if he intended to reorganize a transport system replied no, he was going to organize it. Those now dealing with problems of reeducation are not without ground for similar feeling. "Don't shoot the schoolmaster; he is doing the best he can," but the responsible directors of educational policy should see to it that efficient training does not always remain a chief privilege of feeblemindedness.

F. L. WELLS.

THE CAUSES OF DEPENDENCY; BASED ON A SURVEY OF ONEIDA COUNTY. By Chester Lee Carlisle, M.D., Director. Albany: State Board of Charities, 1918. 465 p. (Eugenics and Social Welfare Bulletin, 15.)

The object of this investigation was to study the causes of dependency; special emphasis, however, has been placed throughout on the relationship between dependency and mental disorders; and thus the greater part of the report is devoted to a survey of mental disorders in Oneida County.

An enumeration was made of cases of mental deficiency, epilepsy, delinquency, and insanity both in institutions and in the communities. The method of enumeration of cases in the communities was the now classical one of following up leads of social maladjustment: "A much better way of getting at those cases which show by their symptom-behavior that they are incapable of making adequate adjustment to the demands of reality and the canons of organized society is to search the records of our public offices and to follow up the cases there found who have shown physical breakdown, economic dependency, odd or anti-social conduct. This plan was adopted and the investigators of the

Bureau of Analysis and Investigation reviewed such records and interviewed poor-law officers, town clerks, justices of the peace, district superintendents of schools, teachers, doctors, clergymen, relatives, friends, and any other reliable person whose judgment in this matter was considered dependable."

The total number of mental defectives found in the county was 1,229, i. e., about 0.73 per cent of the entire population. Of this number only 210 were in institutions and 1,019 living in the communities. These statistics are exclusive of epilepsy, insanity, delinquency, and some physical defects producing dependency.

A great deal of material is exhibited in detail showing the hereditary nature of the mental disorders underlying dependency. Dr. Carlisle gives credit for the careful compilations of material, which must have taken years, to investigators employed by the Bureau, particularly Marion Collins, Catherine E. Conway, Evelyn H. Ellis, Florence G. S. Fischbein, and Gertrude E. Hall.

The data revealed by the investigation fully confirm the previous findings of similar surveys: Social maladjustment, particularly dependency, rests, in large measure, on constitutional mental defect, which, in turn, is due to bad heredity. The bulk of the cases require institutional custody for the benefit of themselves, their communities, and future generations. Existing institutional provision for such cases is far from adequate. A. J. ROSANOFF.

INSTINCTS IN INDUSTRY; A STUDY OF WORKING-CLASS PSYCHOLOGY. By Ordway Tead. Boston: Houghton, Mifflin Company, 1918. 221 p.

Tead is amongst the many sociologists who claim the late Professor Carleton H. Parker as inspiration; he calls his work an elaboration of Parker's suggestions. Whereas the psychologist on the one hand and the medical man on the other may question the title of sociologists to write textbooks on psychology, nevertheless this book is worth while. Tead says that the psychology of employers has been interpreted by Taussig in his *Inventors and Money Makers* and by Sombart in his *Quintessence of Capitalists*. The mind of the worker, Tead thinks, has been grievously misunderstood. We must see human nature as it is.

The source of Tead's compilation of the instincts is, so far as psychologists go, James' *Principle of Psychology*, McDougall's *Social Psychology*, and Thorndike's *The Original Nature of Man*. He refers also to Parmelee's *Science of Human Behavior*, to *The Great Society* by Graham Wallas, and to Trotter's *Instincts of the Herd in Peace and War*. From the economic side we find reference to Veblen's *The Instinct of Workmanship*, and to Wesley C. Mitchell's *Human Behavior and Economics* (*Quarterly Journal of Economics, 1915*), and to Metchnikoff's *Nature of Man*.

The instincts as revealed in industry are:

1. The Parental Instinct
2. The Sex Instinct
3. The Instinct of Workmanship
4. The Instinct of Acquisitiveness
5. The Instinct of Self-assertion
6. The Instinct of Self-abasement
7. The Herd Instinct
8. The Instinct of Pugnacity
9. The Play Impulse
10. The Instinct of Curiosity

In his consideration of the parental instinct, Tead refers to Galsworthy's *Trial* and to various curious ways in which the parental instinct sometimes favors, sometimes interferes with strikes. A practical application in industrial management is the new so-called "plant mother."

As to the sex instinct, "we must become sex-conscious in our industrial dealings and conscious of the place and potency of sex, not in a smirking, apologetic way, but conscious of it as an essential, and essentially sound and wholesome, constituent of human nature."

Possibly the most interesting part of Tead's work is the chapter on the *Instinct of Workmanship*. It is interesting to note that the International Printing Press Men's and Assistants' Union "has realized, of its own initiative, that there are incompetents and semi-incompetents engaged in the printing art," and also noteworthy that this union proposed to eliminate incompetency by establishing and maintaining a trade school. There is some discussion of sabotage.

Concerning the instinct of possession, reference is made to Robert Tressal's novel *The Ragged Trousered Philanthropists*, 1914.

The chapters on self-assertion and self-abasement are devoted to discussion of the I. W. W. and kindred problems, much upon the late Professor Parker's line, and the I. W. W. also appear in the chapter on the *Instinct of the Herd*, wherein the necessity of transferring employees who have a highly developed herd instinct from lonely jobs is, for example, noted.

The chapter on *The Instinct of Pugnacity* turns in part upon the Colorado Fuel and Iron Company case and the Ludlow strike.

The author has given some study to the theaters and other devices, "fruitful laboratories for the psychologist of industry."

The chapter on *The Instinct of Curiosity* is relatively long. The optimistic point is that the "initial impulse to thinking is instinctive."

Tead concludes that the bases of the conduct in groups are knowable and subject to law, that they are, therefore, controllable, and may be manipulated and varied. Amongst the measures of manipulation and variation, he lists economic, geographic, and the physiological, and psychological. "The demand for an extension of the democratic method is in harmony with the facts of human psychology." We are on the way toward adjusting industry to instinct. We are increasing the amount of self-direction.

E. E. SOUTHARD.

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MENTAL HYGIENE will aim to bring dependable information to everyone whose interest or whose work brings him into contact with mental problems. Writers of authority will present original communications and reviews of important books; noteworthy articles in periodicals out of convenient reach of the general public will be republished; reports of surveys, special investigations, and new methods of prevention or treatment in the broad field of mental hygiene and psychopathology will be presented and discussed in as non-technical a way as possible. It is our aim to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials, and students of social problems will find the magazine of especial interest.

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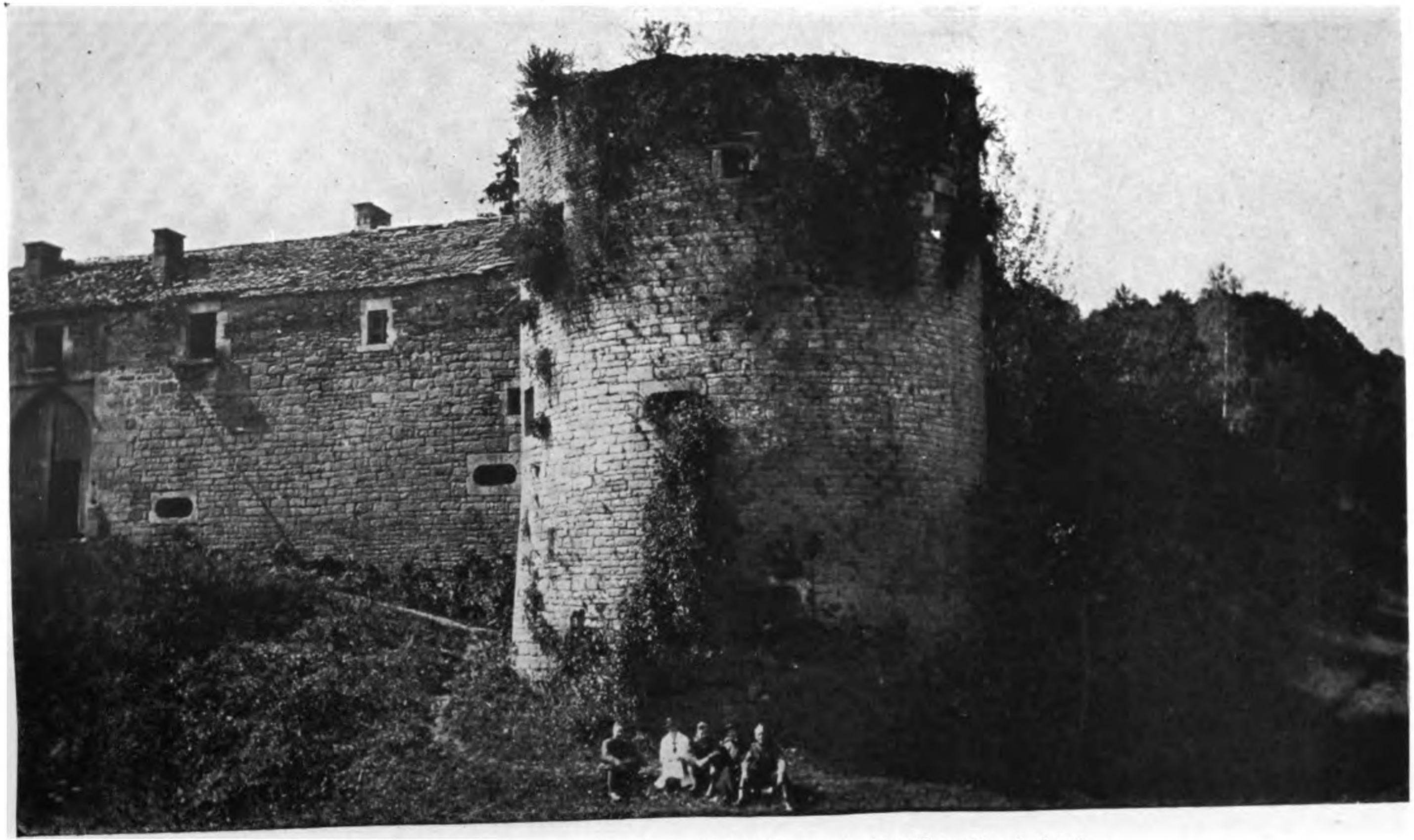

Castle of the Barons of LaFauche on the heights overlooking Base Hospital 117

MENTAL HYGIENE

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MENTAL DEFECT IN A SOUTHERN STATE*

REPORT OF THE GEORGIA COMMISSION ON FEEBLEMINDEDNESS AND THE SURVEY OF THE NATIONAL COMMITTEE FOR MENTAL HYGIENE

Prepared with the assistance of

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OF the states of the Union that are seeking to find a solution of the ever-increasing and urgent problem of feeblemindedness, Georgia promises soon to be one.

That her past policy of indifference and neglect toward this group, probably the most important single group with which a state needs to concern itself, has given way to an awakened interest is attested by the creation, through the Legislature of 1918, of a special commission to investigate the serious consequences of the state's failure to provide proper care and training for this class of persons.

It is not necessary in this connection to emphasize the striking growth throughout the United States of the movement to make provision for feebleminded persons. Suffice it that state-wide surveys, special investigations, and prolonged, painstaking, thoroughgoing scientific researches have demonstrated the positive and close relationship of feeblemindedness to many of society's most serious social problems, and have pointed the way to a possible solution of, or at least a scientific and intelligent approach to, the problems of crime and pauperism, juvenile vice, prostitution, venereal disease, etc.

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* In response to a resolution passed by the General Assembly of Georgia at its 1918 session, the Hon. Hugh M. Dorsey, Governor of Georgia, appointed a committee to investigate and "report such facts and figures as they may secure and make such recommendations as may seem to them suitable to relieve the state of the menace of the uncared-for feebleminded." The committee was composed of the Hon. W. E. Thomas, chairman, Hon. W. B. Baker, Hon. W. F. Crusselle, Hon. J. S. Shingler, Hon. Rhoda Kaufman and, *ex-officio*, Hon. M. L. Brittain and Dr. T. F. Abercrombie. At the request of the committee, The National Committee for Mental Hygiene furnished, as scientific adviser to the committee, Dr. V. V. Anderson, who conducted the survey, and his assistant, Miss Carotta Alexander.

Because of increased knowledge as to the potency of mental defect as a causative factor underlying crime and much of human wretchedness and misery, larger and larger portions of the public budgets in various states of the Union are going into the organization of preventive measures in dealing with these antisocial problems, rather than, as was the old method, into futile later attempts at treatment and cure.

During the last twenty-odd years, provision for the feebleminded has increased in the United States 750 per cent. One after another the various states of the Union have assumed their places in the ranks of those that seek to provide for this most helpless and potentially dangerous class. Not a single institution created for this purpose has ever been abandoned; on the contrary—and this is most significant—all such institutions have long waiting lists, sometimes running up into the thousands, of applicants for care and training.

Georgia is now one of the very few states that have neglected to make any provision for the mentally defective. Even such care as these mentally defective children are receiving is being given after it is too late and they have become so-called "criminals," or juvenile delinquents, or prostitutes, or paupers, or vagrants, or insane persons. These are problems which Georgia recognizes, and for the handling of which she is spending vast sums of money in courts, jails, stockades, venereal clinics, industrial training schools, reformatories, state prison, almshouses, and the like. This is rather as if a community should go to great expense to build a modern hospital at the foot of a cliff, to take care of those who fall over, instead of putting into effect measures to prevent such accidents.

It was thought that an investigation into these existing institutions in the state might furnish interesting and profitable data, indicating what sort of a problem feeblemindedness is to Georgia and throwing light upon the costliness and extravagance of handling the final results of mental deficiency, of taking care of the human wreckage found in brothels, almshouses, etc.

In this connection, we set about making a state-wide survey that would throw light on the relationship of feeblemindedness to juvenile vice and delinquency, as seen in the juvenile court, the State Reformatory for Boys, the Fulton County Reformatory for Boys, and the Georgia Industrial Training School for Girls; to adult crime, vagrancy, and the like, studied in the inmates of the state prison and representative county jails; to prostitution and the spread of venereal diseases, studied in connection with girls arrested for offences against chastity; to pauperism and dependency, studied in typical degenerate families, cases of outdoor relief, and inmates of selected orphanages and almshouses; and finally to education, studied in school children so selected that they would be likely to represent the average school child of Georgia. In this we relied upon the advice and help of the Department of Education.

This method of approaching the problem of surveying feeblemindedness, it was thought, would give more satisfactory results than an ordinary attempt at a census, because the time at our disposal was so short, and the amount of technically trained help was so limited, as to preclude anything like a satisfactory census of the total number of feebleminded persons in Georgia in need of institutional care.

METHODS EMPLOYED

The methods employed in our investigation were as follows:

I. Selection of type of cases needing examination

In no instance did we assume that one individual rather than another, in jail, reformatory, prison, court, orphanage, or school, needed an examination. In no instance did we rely upon personal opinion or general observation to tell us who should or who should not be examined. In each and every case in the juvenile court, in the Industrial Training School for Girls, the State Reformatory for Boys, the Fulton County Reformatory for Boys, the state prison, the county jails, the orphanages, and the public schools visited, a systematic mental examination was given.

II. Character of mental examination given to each individual

Attached to each case record was a history blank. This blank contained data bearing upon the medical, criminal, alcoholic, dependent, etc., history of members of the individual's immediate family. It contained also data on the individual's personal history—developmental facts, both physical and mental; diseases, injuries, etc., affecting the individual during the course of his life, and his present state of physical health; age at which he entered and left school, and grade reached; if in school, the grade and type of work done; the conduct and behavior, including the delinquent history, of the individual, his employment record, particularly statements as to whether he had been regularly or irregularly employed, whether he had only followed odd jobs, or whether he had never done any work or had merely done housework at home; finally, whatever facts could be gathered bearing upon the personality make-up, the mental traits and characteristics, temperamental difficulties, etc., of the individual examined.

This history, in each case, was obtained partly from the individual and partly from the institutional authorities. In the case of the school children, the teacher was relied upon to furnish whatever information it was possible to secure. To be sure, by this method we did not have as well-rounded studies of the careers, particularly of our delinquents, as was desirable, but the data secured we found most helpful in our final diagnosis of the case.

Following the history, a psychiatric examination was given, on the one hand ruling out or eliciting the existence of mental disease or deterioration, on the other, bringing to the fore certain abnormal personality types—the shut-in type, the emotional, the egocentric, the inadequate personality, etc. Finally, by means of psychological tests, the intellectual level and certain abilities of each person were ascertained. In this connection, we used the Yerkes-Bridges Point Scale and some Healy supplementary tests. The supplementary tests were not used in every instance, but in all cases the Point Scale was used.

Assembling all of this data together, we arrived at our diagnosis. Very naturally, we found great numbers of cases in which a decision could not be reached; it is not believed that the results in these cases, whatever they may be, would in any great measure influence the generalizations to be drawn from the data we secured.

It may be noted that we called no child feebleminded who tested as less than four years backward mentally. Amongst colored children a greater degree of backwardness was required. Among white adults, we rarely classed as feebleminded any one who tested beyond ten and one-half years. Among the negroes, owing to the small number of cases studied, we found it very difficult to determine the average adult intelligence; however, in no case did we classify as a mental defective an adult who tested beyond nine years mentally. The great majority of our feebleminded negroes tested eight years and under.

WHAT IS FEEBLEMINDEDNESS?

It may be worth while, before entering into the discussion of the data secured in our investigations, to define feeblemindedness and to call attention to some of the now well-known facts about this condition. Feeblemindedness is "a state of mental defect, existing from birth or from an early age, due to incomplete brain development, in consequence of which the person affected is unable to perform his duties as a member of society in the position of life to which he was born."

Feebleminded persons are not merely dull and backward, but are defective in mentality to such a degree that they are incapable, by reason of this mental defect, of receiving proper benefit from the instruction in the ordinary public elementary school. It is clear, then, that this condition is not due to poverty, or to lack of opportunity for training and education; and since it is the result of abnormal brain conditions, once feebleminded, always feebleminded.

Three types of feebleminded persons are recognized—the idiot, the imbecile, and the moron.

The idiot is so deeply defective that his mental development never exceeds that of a normal child of about two years; he does not possess sufficient mentality to avoid ordinary physical dangers.

The imbecile has a higher mental development than the idiot, but his mentality never exceeds that of a normal child of seven years. He is able to avoid ordinary physical dangers, but can never be made self-supporting.

The moron has a higher mental development than that of the imbecile, but his mental level does not exceed that of a normal child of about twelve years. He is able to avoid physical dangers; he is also capable of being made self-supporting; but, owing to his permanently substandard intelligence, he is not able to manage himself and his affairs with ordinary prudence, and does not have sufficient judgment to compete upon equal terms with his fellows.

Feebleminded persons are especially prolific and reproduce their kind with greater frequency than do normal persons, and through such reproduction provide a legitimate outlet for the exercise of charitable impulses in each generation, and an endless stream of defective progeny, which are a serious drain on the resources of the nation. For this condition is inherited; it is the result, in about 80 per cent of all cases, of defective germ plasm, the expression of defective family stocks, which transmit this condition from generation to generation in accordance with well-known laws of heredity. There is no doubt as to the hereditary potency of this defect in blighting future generations.

Studies of degenerate families in various parts of this country and in certain countries abroad have given startling evidence of the burden feeblemindedness has already become, and the menace it threatens to become, because of its hereditary nature.

In our work here in Georgia, a great number of degenerate families were discovered, but owing to the lack of time and facilities at our disposal, we made little effort to go intensively into this aspect of the problem.

A brief account of some of these families, however, will serve to illustrate the inheritable nature of feeblemindedness, at the same time calling attention to the potency of this defect in causing hereditary pauperism and dependency.

THE RELATIONSHIP OF FEEBLEMINDEDNESS TO PAUPERISM AND DEPENDENCY

Family A

The great-grandmother of this family was a feebleminded woman who died in an almshouse. The grandmother, with sixteen children, a professional beggar, has been dependent upon relief societies and public charities for the last thirteen years; no efforts to make her self-supporting have ever been successful. Ten of these children are known to have been defective, and their families have continuously been dependent upon public funds. One was an epileptic and had an epileptic child. One suffered from tuberculosis. Three were known to be sexually promiscuous and had many illegitimate children. One has recently been in court, charged with attempted murder, for trying to kill her husband with a knife, and is now living openly with another man. In the fourth generation, there are dozens of children, the majority of whom are considered feebleminded by the school authorities of Atlanta.

One, a girl of fourteen, with a mental level of an eight-year-old child, is in the Girls' Reformatory. One, a feebleminded boy, has been in the first grade at school for five years. Another girl has more recently been diagnosed feebleminded and placed in a special class in the public school. Another, a boy, has remained two years in the first grade, and because of his mental deficiency will doubtless never get much further. One, a boy of eight years, has just been before the juvenile court for larceny, and was caught trying to buy ten dollars worth of popcorn. The boy is feebleminded and is urgently in need of proper institutional care and training. Another, a boy, has been in special classes for defective children for the last two years.

Family B

The members of this family live like hermits and avoid social relations with others in the community. The father, who has for years been particularly well known to charitable agencies, is said to have been always peculiar, but in early years he was self-supporting as a peddler. He married a woman of defective mentality, and five children were born, one of whom seems to have been normal. She early left her family and has apparently married well. The other four children are defective mentally. The two oldest boys are now in the reformatory for larceny. The youngest is at home with the father and the girls, one of whom has married a ne'er-do-well who is well known to be a "crook," while the other is a low-grade feebleminded girl with two illegitimate children. They all live together in a little shack of two rooms, and are dependent upon public charity for support.

Family C

The father is a blind beggar of inferior mentality, the mother a feebleminded woman. There are three girls living. The girls, with the father, begged on the streets for a livelihood. All three girls were found to be feebleminded. The oldest is fourteen years old; she went to school from eight to fourteen years, but never got further than the first grade. She has had "spells" since childhood, during which she falls to the ground, bites her tongue, and loses consciousness (epilepsy). During the last year she has begun to hear voices. These voices are very threatening. She is apparently depressed, and remains alone much of the time.

This girl is developing an active mental disorder and is greatly in need of proper hospital treatment.

The next girl, thirteen years of age, went to school from eight to twelve years, but got no further than the first grade. She is said to have had a violent and uncontrollable temper always. She suffers from epileptic seizures. Though she is thirteen years old, she has the mentality of an eight-year-old child.

The youngest girl is nine years old. She has congenital syphilis, and is both physically and mentally dwarfed. She is very selfish and infantile in her behavior, and is considered, at the Girls' Training School where she has been placed, an impossible problem for them to deal with. Though she is actually nine years old, she has not the intelligence of a six-year-old child.

Family D

This is the degenerate family of a seventeen-year-old feebleminded girl who was committed to the Georgia Training School as a wayward child because she was being subjected to immoral and vicious influences. The father, who has been living illicitly with a notorious woman, has a long criminal record, is a syphilitic, and has been charged with keeping a house of ill fame. The mother died of pellagra. Of the seven children, three died in infancy, one of whom was obviously feebleminded. Of the four living children, the oldest sister is a prostitute, one brother a serious alcoholic, and one child has been placed on probation by the court in a good home. The fourth child is the seventeen-year-old feebleminded girl mentioned in this record. When this girl was thirteen years old, she was sexually wayward, and infected with syphilis. Since then her history has been one of sexual promiscuity and petty larceny.

Family E.

This is the family of a sixteen-year-old white feebleminded girl, committed to the state prison for adultery. The father of this girl is undoubtedly a defective and has always been considered by the people in the community "half crazy." He has frequently threatened to kill people, has served a term in the state prison for shooting a man, and has been in court on other charges, such as carrying concealed weapons and the like. He is a drunkard, and frequently moved his family from one shanty to another. The mother was a woman of defective intelligence, a dirty and indifferent housekeeper, with a quarrelsome and ranting disposition.

Eleven children were born to these parents, four of whom died in early infancy. Of the seven living, one is the feebleminded girl referred to above in this report; one, a boy, is a low-grade imbecile; another sister has epileptic attacks. The mental condition of the other four is not known. The feebleminded girl first referred to began a life of immorality at the age of fourteen, had an illegitimate child at the age of fifteen, and since then has been so flagrantly promiscuous that she was committed to the state prison.

It would be possible to go on citing, from the records we have gathered, family after family, illustrating not only the hereditary nature of feeblemindedness, but likewise the important causal relationship it bears to pauperism and dependency in general.

It is already clear to us that vast sums of money are being spent by the charitably inclined people of Georgia in giving relief to unimprovable cases. Our investigations have shown that feebleminded families are allowed to live in the community and propagate their kind, nurtured and cared for by philanthropic efforts and thus encouraged to leave behind them a large progeny of feebleminded; which in turn, protected from infant mortality and carefully nurtured and helped by the good people of the community, reproduce their kind out of all proportion to the normal members. And so goes on the stupid work of preserving and increasing our socially unfit strains through succeeding generations.

We have run across certain pauper feebleminded families in Georgia that have been supported by churches and organized charities for four and five generations. And this is not all, for within certain almshouses are to be found feebleminded persons whom society has allowed to propagate to such an extent that one almost feels it would be better to turn these places into lying-in hospitals.

Lula H., who has for years been an inmate of a certain almshouse, well illustrates this point; her five children are cared for by the good people of the state in a certain orphanage. In our own investigations, the entire almshouse situation of Georgia was not studied, owing to lack of time, but of those investigated, 40 per cent of the inmates were feebleminded persons—persons who are now most helpless and who throughout life have never been self-supporting, but a continuous burden to the community in which they lived. Would it not have been good economy to have prevented this human waste—to have trained these persons to be self-supporting, in cases where this was possible, and at least to have cut short the propagation of their defective strains?

There is another phase of this problem that is worth while discussing here and that is the relationship of feeblemindedness to dependency as seen in connection with orphanages. There are approximately 2,825 children in orphanages and church homes throughout Georgia. Inasmuch as all of the children in these institutions will at a certain period be released into the community and be expected to assume their proper relationship to society, it is a matter of great importance to know what percentage, if any, of these children are feebleminded and thus a potential burden and menace to the community that is to receive them.

In order to get some idea of the problem, a typical orphanage was selected, and all of the children in this institution were examined mentally. There were 101 children, varying in ages from five years up to eighteen years.

TABLE I

Showing the relationship of the actual age of children in a certain orphanage to their mental age

Actual Age	*Mental Age*													
Years	4	5	6	7	8	9	10	11	12	13	14	15	16	17
5	3													
6	6	1	1											
7	1	1			2									
8		2	1	2		1								
9			6		7									
10			1	2	4	1	2							
11				2	4	2								
12			1		3	5	1	3	1					
13					1	4	1	2						
14			1			4	3	1						
15							1	6			1	4	1	
16				1	1								3	1
17							1	1						1

It will be seen from the above table that 13.8 per cent of these children were retarded one year mentally; 15.8 per cent were retarded two years mentally; 14.8 per cent were retarded three years mentally; 16.8 per cent, four years mentally; 6.9 per cent, five years mentally; one case was retarded six years; one case seven years; two cases eight years; and one case nine years. Finally three cases were mentally advanced one year. The details of this examination are shown in Table II.

TABLE II

Showing mental diagnoses of the inmates of a certain typical orphanage

Normal	22.9%
Dull normal	9.9%
Subnormal	34.8%
Feebleminded	28.7%
Psychopathic personality	1.9%
Mentally diseased	.9%
Epileptic	.9%
Total	100%

It will be seen from the above table that 32.4 per cent, practically one out of every three children, are suffering from some serious abnormal mental condition, are mentally defective or mentally ill. Each one of these children is in need of much more specialized training than these institutions are equipped to give him, and this not as a sentimental consideration, but as a sensible measure against future dependency, crime, prostitution, vagrancy, and the like.

Twenty-eight and seven-tenths per cent of these children are feebleminded, and if these figures hold good in other orphanages throughout the state—and there is no reason, so far as we see, why they should not, for the figures themselves are conservative as compared with those coming from many other states—then there are approximately 810 feebleminded children in orphanages and church homes in Georgia. All of these children will be released into the community at that period of life when they are least fitted to meet its obligations, a period when even the most normal children, with good judgment and reasoning powers, good self-control and mental balance, are often subjected to such stresses of temptations as to develop criminal careers.

RELATIONSHIP OF FEEBLEMINDEDNESS TO ADULT CRIME, VAGRANCY, ETC.

Another aspect of the burden which the adult feebleminded impose on society is seen in their failure to measure up to the social and moral mandates of the communities in which they live.

The depredations growing out of their criminal behavior furnish one of the most satisfactory arguments for a state-wide policy of protection against the menace of feeblemindedness. We expected to find, from a study of the inmates of the Georgia State Prison and the inmates of several representative jails, a fairly good picture of the relationship of feeblemindedness to adult crime in this state.

Georgia State Prison

Examinations of all of the inmates of the state prison were made.

There were 216 men in the men's prison, and 126 women in the women's prison. In the state of Georgia, the able-bodied male prisoners committed to the state penitentiary are worked in the so-called "chain gangs," on roads throughout the state. Men suffering from physical diseases, or any serious physical or mental infirmity, are transferred to the state-prison farm. It would be expected, then, that the male inmates of the state prison, being a rather highly selected group, would show a much larger percentage of mental abnormalities, particularly of mental disease, than is to be found in the average state prison. Let it not be understood from this that there is any careful selection, based upon mental and physical examinations, of those who should go to the state-prison farm rather than to the chain gangs.

Of the 216 men examined at the state-prison farm, 111 were white and 105 negroes. They averaged in age from fifteen to eighty.

We rated these individuals according to their physical health, in the following manner: those rated Good showed no evidence, in a cursory examination and in the history given by the prison physician, of any condition of sufficient importance to impair their general health; those rated Fair showed evidence of slight temporary disturbances of health from minor ailments; those rated Poor were suffering from actual physical diseases that definitely impaired their general health; those rated Bad were urgently in need of hospital care and treatment.

A great many of the individuals at this institution (the exact number was not ascertained) were suffering from syphilis and either had been in the past or were at the time of examination under treatment. Sixty per cent of the inmates were in good or fair physical health; 40 per cent were in poor or bad physical health. Five of the cases seen were blind, and eighteen were crippled. The following table shows the offences for which these persons were committed.

TABLE III

Showing offences of inmates at Georgia State-Prison Farm

Burglary	Larceny	Murder	Manslaughter	Assault and battery	Rape	Vagrancy	Selling whisky	Attempt at murder	Robbery	Forgery	Bastardy	Carrying revolver	Embezzlement
30	32	63	21	3	9	7	8	12	5	7	1	2	4
			Wrecking freight train	Shooting cows	Kidnaping	Mayhem	Other Misdemeanors	Seduction	Bigamy	Moonshining			
			1	1	1	1	3	1	1	3			

Forty-two and two-tenths per cent of these individuals voluntarily admitted that they had served previous commitments, were chronic repeaters, the majority having spent years in and out of prisons.

The following table shows the mental level of these prisoners. It should be borne in mind that, with few exceptions, practically all of these individuals were adults, ranging in age from fifteen years to eighty years.

TABLE IV

Showing mental level of 216 men at Georgia State-Prison Farm

Mental Age	*White*	*Negro*
5		4
6	7	5
7	3	4
8	5	24
9	11	18
10	13	18
11	17	26
12	2	—
13	3	1
14	2	—
15	3	2
16	10	3
17	5	—
18	30	—
Total	111	105

Seventy-two and one-half per cent of these individuals had the mental level of the average American child of twelve years or under. Ninety-four per cent of the negroes had the mental level of twelve years or under, while 52 per cent of the whites averaged twelve years or under.

The following table shows the mental diagnoses of these individuals:

TABLE V

Diagnosis	*White*	*Negro*	*Total*
Normal	30	28	58
Dull normal	11	5	16
Subnormal	20	23	43
Feebleminded	17	21	38
Epileptic	5	7	12
Psychopathic	9	3	12
Mental disease or deterioration	12	17	29
Pellagra	3	1	4
Paranoid condition	4	—	4

Sixty-five and eight-tenths per cent of these persons are classifiable as mentally abnormal types—are so handicapped by mental defect or mental disease that the method of treatment they are now receiving will do little in the way of equipping them to live more normal lives when the period of their sentence has been served. Seventeen and five-tenths per cent of the inmates should not be returned to the community at the expiration of their sentence, but should be segregated because of their feeblemindedness.

All women offenders committed to the state penitentiary are confined at the women's branch of the state-prison farm. There were, at the time of our investigations, 126 women so confined—24 white women and 102 negro women. The ages of these women varied from fifteen years up to sixty. Sixty-three per cent, almost two-thirds, were under thirty years of age.

The following table shows the offences for which they were committed:

TABLE VI

Showing offences of the women inmates of the Georgia State-Prison Farm

Larceny	**Burglary**	**Manslaughter**	**Running away from home**	**Murder**	**Accessory to murder**	**Selling whisky**	**Vagrancy**	**Attempt at murder**	**Highway robbery**	**Forgery**	**Immorality**	**Writing insulting letters**	**Arson**	**Drug user**	**House of illfame**	**Mayhem**
28	4	17	1	41	2	1	6	3	8	1	7	1	2	2	1	1

Twenty-three and eight-tenths per cent of these persons had served previous commitments. The small number of repeaters among the women, as compared with the male inmates of the state prison, is noteworthy, but it should be borne in mind that a very large portion of the women who are in this institution are here for serious crimes, many of which were first offences. For instance 50 per cent of these women, or every other woman, was committed either for murder, manslaughter, or attempt at murder.

TABLE VII

Showing the mental level of the women inmates at the Georgia State-Prison Farm

Mental Age	*White*	*Negro*	*Total*
5	2	4	6
6	1	4	5
7	2	8	10
8	3	31	34
9	4	25	29
10	2	13	15
11	5	11	16
12	—	1	1
13	3	2	5
14	—	—	—
15	—	—	—
16	2	3	5

Seventy-eight per cent of these women had the mental level of the average American child of twelve years, or under. The following table shows the mental diagnoses of these women offenders.

TABLE VIII

Diagnosis	*White*	*Negro*	*Total*
Normal	3	25	28
Dull normal	—	2	2
Subnormal	2	20	22
Feebleminded	12	42	54
Mental disease or deterioration	1	4	5
Psychopathic	4	—	4
Epileptic	2	9	11

Seventy-six per cent of these women are classifiable as subnormal, defective, or mentally diseased persons. Forty-two and eight-tenths per cent of them are feebleminded.

County Jails

We felt that an examination of a sufficient number of the inmates of the county jails would give us an insight into another most important aspect of the relationship between feeblemindedness and adult crime. For this purpose two representative jails were chosen, one in southern Georgia and one in northern Georgia. One hundred cases were studied, this being an unselected group made up of all the inmates of the southern county jail and the "run of the mine" in the northern county jail.

Sixty per cent of the inmates of these two jails were under thirty years of age. Thirty-six per cent were white and 64 per cent negroes. Sixty-six per cent were men, and 34 per cent women. The offences for which they were arrested are shown in the following table.

TABLE IX

Showing the offences of 100 inmates of certain county jails in Georgia

	Larceny	Burglary	Murder	Manslaughter	Assault and battery	Rape	Vagrancy	Selling whisky	Attempt at murder	Robbery	Idle and disorderly	Carrying revolver
No.	24	2	7	1	5	2	4	6	5	1	4	2
Per cent	24	2	7	1	5	2	4	6	5	1	4	2

	Bigamy	Other misdemeanors	Possession of whisky	Accessory to murder	Forgery	Possession of stolen goods	Moonshining	Drunk	Failure to register	Drugs	Witness	Bail of trover
No.	1	1	5	1	4	2	15	1	1	3	2	1
Per cent	1	1	5	1	4	2	15	1	1	3	2	1

Fifty per cent of these individuals never got further than the fourth grade in school. Seventy-seven per cent tested, by the Yerkes-Bridges Point Scale, twelve years or under mentally. Sixty per cent had the mental level of the average American child of ten years or under.

The following table shows the mental level of these individuals according to race:

TABLE X

Showing mental level of jail inmates according to race

Mental Level Years	*White* per cent	*Negro* per cent	*Total* per cent
5	—	2	2
6	—	2	2
7	—	3	3
8	3	16	19
9	3	19	22
10	5	5	10
11	7	10	17
12	—	—	—
13	4	—	4
14	1	—	1
15	1	1	2
16	12	4	16
Unknown	—	2	2
Total	36	64	100

From the above table it is seen that 30 per cent of the white inmates have a mental level of ten years or under, while 73 per cent of the negroes have a mental level of ten years or under.

TABLE XI

Showing mental diagnoses of 100 inmates of certain county jails in Georgia

Diagnosis	*White* per cent	*Negro* per cent	*Total* per cent
Normal	12	14	26
Dull normal	1	2	3
Subnormal	10	13	23
Feebleminded	8	26	34
Epileptic	1	4	5
Psychopathic	2	1	3
Mental disease	—	2	2
Drug deterioration	1	—	1
Paranoid	—	1	1
Pellagra	1	—	1
Unclassified	—	1	1
Total	36	64	100

Seventy per cent of the inmates of these jails either are subnormal mentally or are handicapped by such serious pathological mental conditions as feeblemindedness, epilepsy, mental disease or deterioration, etc. Thirty-four per cent are feebleminded persons, with a mental level of ten years or under.

THE RELATIONSHIP OF FEEBLEMINDEDNESS TO PROSTITUTION AND THE SPREAD OF VENEREAL DISEASE

Syphilis and gonorrhea form a combination possibly as productive of evil as any scourge that has ever afflicted mankind. These two conditions are striking at the very source of life and deteriorating the human race.

The high percentage of miscarriages associated with syphilis, the fact that this disease ranks first in its ability to cause destructive diseases of the nervous system, the fact that in its wake follow idiocy, epilepsy, feeblemindedness, insanity, locomotor ataxia, etc., make the proper handling of this condition a matter of the gravest importance to the general public.

The seriousness of gonorrhea, especially to women, and the growing army infected, is a source of much alarm to serious-minded students of the subject.

Few diseases that afflict women are fraught with more permanent harm. In some, it produces only the very mildest symptoms; in others, the fulminating signs are present—acute inflammation of the tubes and ovaries, abscesses, and peritonitis. Between these lie all degrees of pelvic ills, acute and chronic. This disease is a large and important factor in the causation of blindness and many other serious conditions.

In short, we have in syphilis and gonorrhea diseases of such grave significance to society in general and the individual in particular that their existence with such widespread frequency amongst all immoral women imposes a serious duty upon our health authorities.

The one outstanding and most important factor that complicates any and every program for the prevention of venereal disease is the high frequency of feeblemindedness amongst those who are considered most responsible for its spread.

The frequency of this condition is well attested by reports coming from all parts of the country. Of 639 prostitutes studied in the Chicago Morals Court, 62 per cent were considered mentally defective.

Of 243 women studied at the Massachusetts Reformatory for Women, which group included all the women in the institution in whose histories there had been at any time commercialized promiscuous sex immorality, 49 per cent were found defective mentally.

Of 300 prostitutes examined by the Massachusetts Vice Commission, of which Dr. Walter E. Fernald was chairman, the mental defects of 51 per cent were so pronounced as to warrant their legal commitment to an institution for the feebleminded. The Commission states in its report that the women in this group came from shiftless, immoral, and degenerate families; they were industrially inefficient, as shown by the low wages received and by their inability to retain a position, even in unskilled callings; they were very deficient in judgment and good sense; they lacked ordinary general knowledge and practical information.

Two hundred and eighty-nine prostitutes studied by the Baltimore Vice Commission showed 63.7 per cent to be syphilitic.

Twenty-three per cent of the inmates of a large reformatory who were found to be in need of custodial care because of feeblemindedness showed 90 per cent of gonorrhea and 60 per cent of syphilis.

In connection with our survey here in Georgia, we desired very much to secure a study of this problem that might localize interest in the highly important relationship which feeblemindedness bears to the whole question of prostitution and the spread of venereal disease, a question now so prominently before the public because of the praiseworthy campaign being waged by our health authorities.

We were able to secure the mental examination of 122 immoral women and girls. About one-half of these were examined at the Atlanta stockade; the others were court cases, Girls' Training School cases, and individuals confined in jails. They ranged in age from fourteen to thirty-five, and were all guilty of sexual promiscuity. The following table shows the mental diagnoses of these 122 cases:

TABLE XII

Showing mental diagnoses of 122 immoral women

Normal	25.4%
Subnormal	20.5%
Feebleminded	43.5%
Psychopathic	8.2%
Epileptic	1.6%
Mentally diseased	.8%

Fifty-four and one-tenth per cent of these individuals are suffering from serious mental abnormalities, feeblemindedness being the most common condition—43.5 per cent.

It is obvious that these girls are unfitted to compete on equal terms with their normal fellows. Their life histories show evidences of marked economic instability; they have drifted from pillar to post, unable, because of their incompetence, to hold positions sufficiently long to enable them to become self-supporting. The life of prostitution is a simpler and more natural one for them. They are at the lowest ebb of the industrial market, the last hired and the first fired.

With the zeal of the reformer, we herd these feebleminded girls into our venereal clinics and hospitals and, at considerable cost in time and money, we seek to cure them of venereal disease and promptly turn them out into the community to acquire it over again. Are we not acting stupidly in returning to the community girls whose future immoral conduct we can predict with as much certainty as we can that on a hot summer day most of the people will be found on the shady side of the street?

An institution for defective delinquent girls will be a charter of liberty for this most helpless, unfortunate, and potentially dangerous class, taking them from the streets and highways, where they have been the defenceless prey of lust and greed, and placing them in an environment suited to their own particular needs, where they may be made happy and useful; where they may be trained along industrial lines to that degree of industrial efficiency that will enable them in a great measure to support themselves.

Finally, not the least important of all these benefits is the protection such an institution will afford society.

RELATION OF FEEBLEMINDEDNESS TO JUVENILE VICE AND DELINQUENCY

Observers everywhere are united in stating that the sources of criminality lie in conditions of childhood and adolescence. The majority of criminals begin their careers in late childhood. It is this well-recognized fact that has convinced all serious-minded students of this problem that the prevention of crime finds its solution in the proper handling of the juvenile delinquent.

It is not our purpose here to discuss the entire question of juvenile delinquence. This will be taken up in a later special report on the defective delinquent. In this connection, we wish merely to call attention to the very definite relationship existing between mental defect and juvenile vice and delinquency. For purposes of this study, all of the inmates of the Girls' Industrial Training School, the State Reformatory for Boys, the Fulton County Reformatory for Boys, and a sufficiently large group of children from the "run of the mine" in the Juvenile Court of Atlanta were chosen for examination.

Juvenile Court

A careful mental examination of each child coming before the court was made. It was thought that one hundred records would give us sufficient data to permit of fairly safe generalizations as to what percentage of children coming before the court were feebleminded. Of the children studied, thirty-one were negroes and sixty-nine were white children. They averaged in age from five years up to seventeen. The following table gives an idea of their offences, or the reasons for their being brought before the court:

TABLE XIII

	Incorrigibility	Disturbing the peace	Associating with immoral person	Robbery	Burglary	Larceny	Running away from home	Truancy	Improper or incomplete guardianship	Vagrancy	Shooting	Cursing and fighting
No.	8	1	2	1	5	34	18	1	23	4	1	2
Per cent	8	1	2	1	5	34	18	1	23	4	1	2

It is of interest to note that 23 per cent—almost one out of every four children—had been in court before, some a great number of times. Many have been arraigned four, five, and six times. We see here the beginnings of recidivism, which shows itself later on in confirmed criminality. As said before, we will not enter here into a discussion of the home conditions, developmental factors, both physical and mental, that act as important causes underlying the behavior of these juvenile delinquents; nor will we go into questions of employment, personality traits, and mental characteristics, all of which, however, are essential in considering the problem of delinquency.

TABLE XIV

Showing the relationship of actual age to mental age

Actual Age	*Mental Age*														
Years	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
5	1														
6					1										
7	1					3									
8		1	1		1	2		1							
9						1	3								
10				1	3	1	1								
11			1	2	1	3			2		1				
12					1	3	3		1		1	1		3	
13							1	6			3				1
14					1	3	3	5	5		1	2	1	4	
15						1	1	1	4	1		1	2	3	4
16															
17										1	1				

It will be seen from the above table that 15 per cent of these children test at age; that 24 per cent test above age, are supernormal; and that 61 per cent test below age. Seven per cent are retarded one year; 1 per cent are retarded two years; 22 per cent, three years; 17 per cent, four years; 7 per cent, five years; 5 per cent, six years; and 2 per cent, seven years.

In short, 14 per cent of these children were retarded five or more years mentally. These fourteen cases—together with three children who were retarded four years mentally, but whose past history gave marked evidence of feeblemindedness—constituted our seventeen feebleminded children.

The following table will show the mental diagnoses of these one hundred cases, as arrived at by carefully gathered social histories and psychiatric and psychological examinations. It will give also some idea of mental conditions as they are found amongst the two races.

TABLE XV.

Showing mental diagnoses of 100 juvenile-court cases as related to race

Diagnosis	*White*	*Negro*	*Total*
Normal	24	12	36%
Dull normal	4	2	6%
Subnormal	17	13	30%
Feebleminded	13	4	17%
Psychopathic	8	—	8%
Epileptic	3	—	3%

Fifty-eight per cent of these children—every other child—is handicapped by some form of mental defect or abnormality; 17 per cent are feebleminded.

Simply trying out these children again and again on probation, the use of judicial reprimand, or sentencing them for short terms, will never solve the problem or prevent the careers that these mental unfortunates give promise of developing.

Fulton County Reformatory for Boys

This institution is supplied by the juvenile court of Atlanta. It contained, at the time of investigation, 113 boys, all white, varying in age from nine years to seventeen, committed for the following offences:

TABLE XVI

Showing offences of inmates of Fulton County Reformatory

Larceny	Burglary	Shooting another	Running away from home	Idle and disorderly	Robbery	Forgery	Incorrigible	Vagrancy	Assault and battery	Sex offence
55	19	1	9	4	3	4	13	3	1	1

Thirty-seven and two-tenths per cent of these persons were first offenders, while 62.8 per cent—almost two out of every three boys—had had previous commitments. Forty and seven-tenths per cent of the total number of inmates had each several arrests to his credit—were recidivists, chronic repeaters.

It is a matter of no small concern to note the striking evidence of failure of society, the court, and the institution to check the progress of these delinquent careers.

The two following tables will throw much light on the reasons for this failure, and will point toward the proper method of treatment of these cases.

TABLE XVII

Showing the relationship of the actual age to the mental age

Actual Age	*Mental Age*											
Years	7	8	9	10	11	12	13	14	15	16	17	18
9	1											
10		4			2							
11	1	2	1		1							
12		1	2	4	1		3			2	1	
13			3	1	4		2	1	1	2		
14		1		3	6		2	1	1	4	2	5
15		1	3	1	6		2	1	2	2	3	4
16		2			4		2			6	1	3
17					1		1					3

From the above table, it will be seen that 14 cases are at age, 38 cases are above age mentally, and 61 cases—approximately 54 per cent—are mentally below their normal age.

TABLE XVIII

Showing mental diagnoses of 113 inmates of Fulton County Reformatory for Boys

Normal	49
Dull normal	5
Subnormal	38
Feebleminded	17
Epileptic	2
Psychopathic	2

From the above table, it is seen that 52.2 per cent of the boys in this institution are classifiable in terms of deviation from normal mental health, while 15 per cent of the inmates are feebleminded. Every other boy is certainly in need of more individualized treatment and training than this institution is at present equipped to give him.

State Reformatory for Boys

This institution is located at Milledgeville, Georgia, near the state prison.

At the time at which this investigation was made, there were 112 boys in this institution, varying in age from nine years to twenty. Fifty-two were white boys and sixty were negroes. The races are separated, there being one building for the white and another for negro boys.

The following table shows the offences for which these boys were committed to the reformatory.

TABLE XIX

Showing the offences of 112 inmates of the State Reformatory

Larceny	Burglary	Shooting at another	Incorrigible	Carrying revolver	Arson	Robbery	Running away from home	Assault and battery	Other misdemeanors	Vagrancy	Forgery	Manslaughter
62	19	3	4	1	2	1	3	1	8	4	2	2

Forty-three and seven-tenths per cent of these individuals had had previous commitments. Almost every other boy had shown evidence—not only in the conduct that resulted in his present arrest, but in delinquent behavior for a period of years—of such persistent antisocial tendencies as to constitute a clear deviation from average normal conduct. Approximately 74 per cent were never able to get farther than the fourth grade in school.

About 80 per cent were retarded from one to eight years in their mental development. Eleven were retarded one year; eight, two years; thirteen, three years; twelve, four years; sixteen, five years; eleven, six years; fourteen, seven years; and five, eight years. The following table shows the mental diagnoses of these cases:

TABLE XX

Normal	35
Subnormal	36
Borderline mental defect	7
Feebleminded	27
Epileptic	4
Psychopathic	3
	112

Sixty-eight and seven-tenths per cent were suffering from nervous or mental abnormalities. Twenty-four and one-tenth per cent—one out of every four cases—were feeble-minded.

Georgia Training School for Girls

We were exceptionally fortunate at this institution as, through the hearty coöperation of the superintendent and the help of two very capable workers from the Children's Bureau at Washington, we were able to secure some instructive case histories of delinquent and defective girls. The use of several of these cases in connection with this part of the report would, we believe, be both interesting and profitable, but owing to lack of space, it will be necessary to limit these illustrations to two or three cases, the histories of which will follow the general discussion of the findings at this institution.

One hundred girls were examined at this training school, which included practically all the inmates of the institution, with the exception of five or six girls who were received during the time that this investigation was being made. They were all white girls, averaging in age from nine years up to nineteen. The following table shows the offences for which they were sent to the institution:

TABLE XXI

	Improper guardianship	Incorrigible	Immorality	Associating with vicious and immoral persons	Larceny	Vagrancy	Burglary	Arson	Other delinquencies	Dependent
No.	5	36	19	23	7	5	1	1	2	1
Per cent	5	36	19	23	7	5	1	1	2	1

Fifty-one per cent of these girls had never got further than the fourth grade in school; 70 per cent were retarded one or more years; 49 per cent were retarded four or more years; 12 per cent were advanced one year; 2 per cent were advanced two years; 2 per cent were advanced three years; and one was advanced five years mentally.

TABLE XXII

Showing the diagnoses of 100 girls at the Georgia Training School

Normal	31	31%
Subnormal	23	23%
Feebleminded	27	27%
Epileptic	3	3%
Psychopathic	14	14%
Mentally diseased	2	2%
	100	100%

Sixty-nine per cent of the inmates of this institution are not to be considered normal girls—are classifiable in terms of deviation from average normal mental health.

Twenty-seven per cent of them are feebleminded and will never be able to take their place in society and compete with their normal fellows. Nevertheless, at the age of twenty-one they will be returned to the community. Though adult in years and fully grown in their physical development, they will still remain mental children with the intellectual level of eight, nine, and ten years, and with just the same degree of self-control, moral judgment, planning ability, and discrimination.

Summary of Juvenile Delinquency

Is it not clear from the above tables that in our institutions for delinquent children we are dealing with a strikingly large number of repeated offenders, of recidivists, in whom we have failed to accomplish that which we set out to accomplish?

At least 50 per cent of these delinquent children are repeated offenders, but behind this there are facts in their careers that should have called our attention to them at a much earlier period. At least 60 per cent never got further than the fourth grade in school. Correlated with this are the striking facts that 66 per cent of these children are retarded one or more years in their mental development; that at least 60 per cent should be dealt with by entirely different methods from those that are suitable in the case of normal-minded children; while 22 per cent are undoubtedly feebleminded and in need of special institutional care, adapted to their particular mental weakness.

Illustrative Cases

A feebleminded negro boy of fourteen years, with the mind of a seven-year-old child, is serving a reformatory sentence for attempting to rape a twelve-year-old white girl.

Two low-grade feebleminded negro girls, with the mental levels of seven and eight years, have been committed for life to the state prison for two murders.

A fifteen-year-old feebleminded boy, committed to the state reformatory for vagrancy, has been a repeated offender, having been in court several times before for larceny and the like. The boy's great-grandmother was apparently a very nervous, unstable, and poorly balanced woman. The boy's grandfather was considered a "bad character"—had a criminal record, was alcoholic and immoral. The boy's mother had a violent temper, was very emotional, had a habit of running into the streets and screaming when angered. One sister had a very violent temper and would tear her clothes to pieces. The mother married three times; by the first husband, she had five children, all of whom had criminal records and were sent to institutions. One girl, while an inmate of one of these institutions, whipped the matron and had to be transferred where more severe disciplinary measures could be secured. After her release, she married, but very soon separated from her husband and deserted her three little children. Another sister was a prostitute and ran a road house. She married a man who committed a murder. And so the story of delinquency, prostitution, crime, etc., runs through the entire family.

The subject of our story, one of the sons, very early in life proved impossible to control. He was described as indolent, dishonest, untruthful, stubborn, and "has no morals"; he was placed out by different agencies in various families, but either ran away or had to be taken away because the families would not tolerate him. Twice he escaped from the detention house while his trial was pending. Finally he landed in the state reformatory. Though this boy is fifteen years old, he has the mind of a little child and will always remain a mental dwarf. He promises a very dangerous career, and nothing could possibly be more stupid than the present policy of locking this feebleminded boy up for a short term of confinement and then turning him out again no better fitted for life than he was the day he entered prison.

THE RELATIONSHIP OF FEEBLEMINDEDNESS TO THE PUBLIC SCHOOLS

There is possibly no other question so vital to the good of our elementary public schools as that of what shall be done with mentally defective children. They form from 2 to 4 per cent of the population of these schools.

All educational authorities agree that they are unable to profit by the ordinary methods of public-school instruction. They are a burden to the teacher and a constant menace and hindrance to the other children in the classes. Their stupidity makes them the dunces of the schools, and their simplemindedness renders them the constant butt of jokes and the perennial source of childish ridicule.

But this is not all. These defective children later on become a burden and a danger to the community in which they live, in that they become recruits to the vast army of prostitutes, criminals, paupers, vagrants, and the like that fill our courts, jails, prisons, almhouses and provide the unimprovable cases for organized charity.

The foregoing tables show the penalty we are paying in dollars and cents and wasted human lives for our neglect to provide for the care and training of these feebleminded persons at a time when prevention of much of their antisocial conduct, dependency, and degradation would have been possible. In our present investigation we set about to determine what proportion of the school children of Georgia were mentally defective and thus in need of more specialized care and training than they are at present receiving in the public schools. In this we were very ably assisted by the State Department of Education.

A survey was made of typical schools, chosen by Mr. M. L. Duggan, the representative of the State Department of Education, in three different sections of the state—the mountainous section, the mill and rural section of north-central Georgia, and a large urban community in southern Georgia. It was our aim to divide these three sections equally and study about the same number of children in each section of the state. In every instance where a school was selected, an examination of every child in the various grades was made. In this way we secured examinations of 915 white school children and 120 negro children. The following table gives some idea of the actual age of these children and the amount of mental retardation there is present:

TABLE XXIII

Showing the relationship of the actual age of these children to their mental age

Actual Age	*Mental Age*														
Years	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
5		1	1	2	1										
6	1	5	7	9	10	6	2								
7		1	1	10	20	27	5	3	3						
8		1	2	4	12	36	18	23	7		2				
9		2	2	2	7	30	22	27	17	3		1		1	
10				1	2	15	31	26	31	7	4	1	1	10	
11						15	22	20	33	4	10	13	3	11	
12						7	10	12	32	17	2	4	2	16	
13						4	10	7	19	7	24	4	1	11	
14						1	8	5	11	3	10	10	5	23	
15							1	3	9	2	1		3	9	
16		1					2	2	3	1	3	1	1	7	
17									1	2	2	1		1	

Three hundred and forty-five cases, or 37.7 per cent, were retarded from one to six years mentally; 166 were retarded one year; 86 were retarded two years; 58 were retarded three years; 26 were retarded four years; 6, five years; 3, six years. Thirty-five, or 3.6 per cent of the cases, were retarded four years or more mentally.

Two hundred and sixty-seven, or 29 per cent, were advanced from one to seven years mentally. One hundred and five were advanced one year; 65 were advanced two years; 41, three years; 21, four years; 17, five years; 15, six years; and 3, seven years.

There could be no greater fallacy than to assume that all children react alike to the same standards of public-school training. We will hardly have the space to enter into a discussion of the energy, time, attention, and patience that the children who are retarded mentally exact of the grade teacher, to say nothing of the harm they are doing to the more normal children in taking time and mental energy that could be much more profitably devoted to those capable of proper progress. The expense of the mentally retarded is seen in their repeating of grades.

The following table speaks for itself. It was impossible to secure from the teachers in all the schools visited an idea of the number of children who were repeating grades, this because of the frequent change in teachers. Schools were found that had two or three teachers in one year. The following school was selected because it contained exact data on every child that repeated grades. There were 185 children in this school.

TABLE XXIV

Showing number of children who repeated grades in a certain county school

Grade	*Repeating grade once*	*Repeating grade twice*	*Repeating grade three times*
1st	35	1	3
2nd	32		
3rd	28		
4th	9		
5th	12	1	
6th	2	1	
Totals	118	3	3

There were 118 repeaters in this school. Three and two-tenths per cent of these children had repeated grades more than once.

In every classroom throughout the state are to be found pupils who are not able to keep step with the rank and file of children. Some of these are backward because of prolonged absence from school, serious illness, physical defects, lack of interest, etc., and are in need of specialized treatment and training. But after these are eliminated, there still remain a few children who perplex both principal and teachers; who, no matter what individualized care and treatment they may receive, fail to progress properly. They show an incapacity for profiting by ordinary school instruction and can never keep up with the grade work, because they are mentally defective. They are a serious misfit in the schools, and they greatly hinder the proper training of normal children.

The following table gives some idea of the size of this group in the schools visited by us throughout the state:

TABLE XXV

Showing the mental diagnoses of 915 white school children

Supernormal	87
Normal	468
Dull normal	131
Subnormal	177
Feebleminded	32
Epileptic	2
Psychopathic	18
Total	915

Three and four-tenths per cent of the children studied were mentally defective.

The full significance of these figures is not to be seen only in the failure of these children to measure up to the ordinary public-school instruction, but in the promise they give of future social difficulties, of industrial inefficiency, of economic instability, of prostitution, crime, vagrancy, and the like.

These defectives will always be mental children, and upon reaching the chronological age of twenty-one, they will, without the proper sort of training, be little better able to measure up to the moral and social mandates of the community in which they live than they are to-day as children in the public schools; and this not because of any innate wickedness or viciousness on their part, but simply because of the fact that a person whose intelligence develops only to the degree attained by the average child of eight or ten years is always a misfit in a form of society which has been arranged for people whose minds continue to develop until the changes of old age begin.

We did not have sufficient data to make generalizations concerning the negro school child. With the time at our disposal, it was possible to secure the examination of the children in only one school. This was in a colored school in southern Georgia. This school contained 120 children. The superintendent stated that practically all of the other schools in the county were closed. One colored school that was visited contained only six pupils. The following table is offered for whatever it may be worth. We attempt to make no generalizations.

TABLE XXVI

Showing mental diagnoses of 120 negro school children

Normal	27
Subnormal	80
Feebleminded	13
Epileptic	0
Psychopathic	0

It was found that 22 of the children were retarded one year mentally; 26, two years mentally; 25, three years mentally; 17, four years mentally; 12, five years mentally; 5, six years mentally; 12, seven years mentally; one was advanced one year. As said before, we do not propose to draw any conclusions bearing upon the negro school children of Georgia from this table.

Summary

The results of the survey may be briefly summarized as follows:

Forty per cent of the inmates of the almshouses investigated were feebleminded, and feebleminded families were found in the state that have been supported by church and organized charities for four or five generations.

A study of a typical orphanage showed that 28.7 per cent of the children were feebleminded. If the same percentage exists in the other orphanages of the state, then there are at least 810 feebleminded children in orphanages who need special care and training in a school for the feebleminded.

Seventeen and five-tenths per cent of the male inmates of the state-prison farm were feebleminded. The striking fact at this institution was not so much the presence of feeblemindedness, which we had expected to find in a larger proportion of the inmates than was the case, but the great number of other forms of mental abnormality, mental disease and deterioration, epilepsy, and the like. Undoubtedly the able-bodied mental defectives are placed out in the chain gangs. Sixty-five and eight-tenths per cent of the inmates of this institution are classifiable in terms of deviation from normal mental health. Of the women inmates of the prison, 42.8 per cent were found to be feebleminded. In the two typical county jails examined, 34 per cent of the inmates were feebleminded, with a mental level of ten years or under.

Of 122 immoral women examined, 43.5 per cent were found to be feebleminded. The present policy of treating these feebleminded girls for venereal disease and then turning them out into the community to acquire it over again is a costly one. Probably the greatest single factor in the spread of venereal disease is the feebleminded prostitute. An institution for defective and delinquent girls and women is most urgently needed.

Of 100 cases of juvenile delinquents studied in the juvenile court, 17 per cent were found feebleminded. Fifteen per cent of the Fulton County Reformatory for boys were feebleminded, 24.1 per cent of the inmates of the State Reformatory for Boys, and 27 per cent of the inmates of the Georgia Training School for Girls. It is these feebleminded delinquent children that later on become the chronic recidivists, as is seen in our jails, adult criminal courts, and state prisons.

Finally, 3.5 per cent of the children examined in the public schools were found to be feebleminded. These are the children who are to become the "grist" of our future courts, jails, reformatories, and state prisons, and to form the very backbone of the vast and grim procession of paupers, criminals, and prostitutes of to-morrow.

Conclusions

Would not the experience of the United States Army in the present war prove valuable to every state in the Union?

At the beginning of the war, the War Department requested the authorities at the Fort Leavenworth Disciplinary Barracks to estimate the increase in delinquency to be expected with the drafting of an army of three million men. This estimate was to be based upon the experience of the Civil and Spanish Wars and the Mexican Border trouble. The official estimate was that it would be necessary to provide for 50,000 delinquents. As a matter of fact, 5,000 was the highest mark ever reached—one-tenth of the expected increase. It may be remarked that every soldier, on his entrance into the army, was given a mental examination, and thus the mentally abnormal and unfit were rejected. Correlated with this, we find a striking decrease in delinquency—one-tenth of the expected increase.

Furthermore, in civil life, it is found that at least 50 per cent of the inmates of the state prisons throughout the country are suffering from abnormal nervous and mental conditions. Now, with the elimination of the most serious cases as unfit for army life, it was found that only 10 per cent of the 5,000 delinquents suffered from any abnormal nervous or mental condition.

Is there not a lesson here for us in the handling of our serious antisocial problems? Would not the early detection of the mentally abnormal, the peculiar, and the subnormal children in our public schools, and the provision of proper care and treatment for the conditions they present, go far towards solving the problems of our future criminal and dependent classes?

In the hard facts presented in the foregoing tables there is no sentiment. We have shown what in later life becomes of the feebleminded children in the public schools. We have shown that mental deficiency forms the very root of crime, prostitution, hereditary pauperism, and the like, conditions for which the state is spending vast sums of money.

These problems are preventable, in that the one sensible, ready, and efficient measure that can be carried out is to dam the stream near its source. As far as delinquency in the mentally defective is concerned, there need be no delinquency if the defective as such is reckoned with early.

Proper provision for the feebleminded at a time when these antisocial problems are preventable is an ideal that this state can most profitably set itself to achieve.

Expense is not an excuse. It is within our power to deal effectively with this problem, for we are already bearing the much greater expense of paying for our failure to deal with it.

It is not, then, a question of whether we wish to pay for feeblemindedness. We are doing that, and in the most costly manner possible, both in dollars and cents and in human wretchedness and misery. It is simply a question of whether we will pay blindly or intelligently—whether we will pay in crime, in courts, in reformatories, in prisons, in almshouses, or in prevention, in intelligent care and training of these feebleminded children in schools and institutions suited to their particular needs, in special-class instruction of them in the public schools, and proper supervision of them in the community.

RECOMMENDATIONS

I. Training School and Farm Colony for Feebleminded Persons

(A) Custodial Department

This department includes the lower grades of idiots and epileptics. Some of these children are as helpless as infants, incapable of standing alone or of dressing or feeding themselves. The chief indication with these lower-grade cases is to see that their wants are attended to and to make them comfortable and happy as long as they live; but even with these cases, much improvement is possible in the way of teaching them to wait on themselves, to dress and undress, to feed themselves, and to give attention to personal cleanliness and habits of order and obedience. In this way, quite a large group, even of these low-grade cases, may be made less troublesome, and the burden and expense of their care may be considerably lessened.

(B) The Training School

Here manual training and other methods are especially adapted to the training of feebleminded children. Dr. Walter E. Fernald has said "these methods of physiological training of the senses and faculties, of exercising and developing the powers of attention, perception, and judgment, by teaching the qualities and properties of concrete objects, instead of expecting the child to absorb ready-made knowledge from books, of progressively training the eye, the hand, and the ear, these were the methods formulated by Séguin," etc.

Dr. Fernald further says: "The most prominent feature of our educational training to-day is the attention paid to instruction in industrial occupations and manual labor. In this 'education by doing' we not only have a very valuable means of exercising and developing the dormant faculties and defective bodies of our pupils, but at the same time we are training them to become useful men and women. Carpentering, painting, printing, brickmaking, stockraising, gardening, dairying, farming, domestic work, the manufacture of clothing, boots and shoes, brooms, and brushes, and other industries are now successfully carried on by the pupils in these schools, in connection with the strictly mental training."

(C) The Farm Colony

An essential part of this school for the feebleminded is the farm colony that should be attached to it. A large proportion of the feebleminded can be usefully and profitably employed, if intelligently directed. They can clear waste land, grub bushes, remove stones, build fences, make roads, renovate orchards, drive teams of oxen or horses, milk cows, feed pigs, take care of chickens, cultivate land, and gather crops. They can excavate for buildings, haul stones for foundations, make brick and cement blocks, and do the necessary painting to keep the buildings neat and attractive. In states where the colony plan has been utilized and intelligently directed—as at Templeton, in Massachusetts, under the direction of Dr. Fernald—large crops have been yearly grown and unusual success has been obtained from this method of treatment. Many of the children who, at the training school, found the necessary restraint irksome, are free at the farm colony to go and come. They may wander freely in the woods, and if there is a stream nearby, they may go in bathing. The results of their labor become more evident. Where they make their own concrete blocks and construct their own buildings, they feel that they are really doing something worth while, and appreciate the fact that they are making their own home. The destructive tendencies often marked in the schoolroom find their outlet here. Instead of breaking windows, destroying furniture, or setting fire to buildings, as these children so often do when confined in penal institutions, they cut down bushes, pull up stumps, burn brush heaps, and make waste land available for farming, thus increasing its value and decreasing the cost of maintaining themselves as the wards of the state.

(D) Kind of Land and its Location

Cheap land should be bought, with good water and drainage facilities—undeveloped land that can be made useful and valuable by clearing, draining, and preparing for cultivation. This work the feebleminded can do. Barren or near-barren land must not be selected. The location should be far enough away from cities so that it can be purchased for its inherent agricultural value, but not so far as to be inaccessible. The more accessible the feebleminded person is to his family and friends, when in the institution, the more readily will the latter consent to such care.

(E) Type of Buildings

The feebleminded can be economically housed if we discard the mistaken idea of elaborate buildings and equipment. At the same time, they can be made happy, useful, and contented. Simple buildings, not more than two stories high, of frame, cement, or cement block, may be used. It is probably more economical to build with concrete blocks, where the boys can do a large part of the work themselves. The buildings should house from fifty to one hundred persons each. This presents the possibility of segregation of different types. Not only can the negroes be separated from the whites, and the boys from the girls, but the vicious and delinquent types from the more tractable types, the high-grade cases from the low-grade, the epileptics, etc.

(F) Medical Superintendent

It is probably needless to add that, inasmuch as the innumerable problems confronting the superintendent of such an institution are so essentially medical in nature, having to do with the various physical and mental aspects of feeblemindedness, only a physician trained in this particular field should be at its head.

II. Special Classes in the Public Schools

In every school district throughout the state, there are children who are not receiving educational benefit commensurate with the effort and money expended on them. These children are a drag on the classes. These backward children have just as much right to education as the normal child. This education can be made of the largest profit to the child and to society if it is directed along lines that will give him industrial training and habits fitted to his particular capabilities and adaptabilities.

Through the organization of special classes, the normal class and the teacher are relieved of a drag. "The retarded and slow children are encouraged and speeded up." "The intractable children become interested in school work." The defective children are trained to do the things they are capable of doing. By proper correlation of the work of these special classes with the State Institution for the Feebleminded, many of these children may be prepared for happy and useful lives under state supervision.

III. State-wide Supervision

If these special classes in the schools are to be of the greatest service, then some plan of supervision and control of the feebleminded is necessary. Are we to look after these defective children in the special classes in schools until they are fourteen, fifteen, and sixteen, and then suddenly throw off all responsibility and turn them out into the community? The school and the special class furnish us with a nucleus for a system of supervision, enable us to detect early the feebleminded child and to give him proper supervision or institutional care. If, now, there is accessible to the school and the special classes (1) a mental clinic for the detection of the feebleminded child and the diagnosis of his particular possibilities, capabilities, and adaptabilities; (2) a social-service department, containing workers to act as visiting teachers, keeping in touch with both child and home; and (3) a vocational and employment bureau, we have the beginnings of an effective machinery for supervising the feebleminded in the community. The need for some properly constituted authority to take on the supervision of the feebleminded is urgent. As Dr. Fernald has well said, "At any given time it is a matter of chance as to what state or local or private organization is being perplexed by the problems they present. They are shifted from one organization to another as soon as possible." There should be some authority to advise and compel proper care and protection for this numerous and dangerous class.

IV. Mental Clinics

The creation of mental clinics throughout the state, manned by the staffs of the state hospital for the insane and the school for the feebleminded, to act as clearing houses for the defective, the subnormal, the peculiar, and the nervous children of the public schools, the abnormal and delinquent children of the juvenile court, and the various complex mental problems in the home and in the community, will do much toward the prevention of insanity, pauperism, and criminality in the oncoming generation.

V. Laws for the Commitment of the Feebleminded

There should be laws containing provisions for the diagnosis, commitment, parole, and discharge of feebleminded persons, stating who are qualified to diagnose feeblemindedness and making the usual provisions for the protection, care, training, and segregation of mental defectives.

A STATE PROGRAM FOR THE CARE OF THE MENTALLY DEFECTIVE

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IT is now generally understood that the feebleminded and the progeny of the feebleminded constitute one of the great social and economic burdens of our modern civilization. We have much accurate knowledge as to the prevalence, causation, social significance, prevention, and treatment of feeblemindedness, its influence as a source of unhappiness to the defective himself and to his family, and its bearing as a causative factor in the production of crime, prostitution, pauperism, and other complex social diseases. The literature on the subject has developed to enormous proportions. An intelligent democracy cannot consistently ignore a condition involving such a vast number of persons and families and communities, so large an aggregate of suffering and misery, and so great economic cost and waste.

Nearly every state in the Union has already made a beginning in the way of a program for dealing with the mentally defective, either directly or indirectly. The development of this program in the different states varies greatly in degree and method. Even the most advanced states have not yet formulated a plan for reaching all of the feebleminded of the state. It is safe to say that no state has yet officially taken cognizance of 10 per cent of the mentally defective persons in that state. No state has even ascertained the number of feebleminded in the state, their location, or the nature and expression of their defect. The great majority of these defectives receive no education or training and no adequate protection and supervision. We know that feeblemindedness is highly hereditary, but in most states there is no legal obstacle to the marriage of the moron, the most numerous class of the feebleminded.

There are many reasons for the lack of a formal accepted program. The problem cannot be solved by a simple formula, which can be expressed in one definite piece of legislation. It is an infinitely complex problem, varied according to age, sex, degree and kind of defect, presence or absence of hereditary traits or criminal and antisocial proclivities, home conditions, etc. The idiot, imbecile, and moron present different needs and dangers. Each of these groups has different troubles, according to age and sex. Rural, sparsely settled communities, with homogeneous racial populations, have conditions pertaining to the defective which differ from those of urban industrial centers, with cosmopolitan racial complications.

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* Read at the Child's Welfare Conference called by the Children's Bureau of the Department of Labor, and held at Washington, D. C., in May 1919.

The first step in a rational program would be the beginning of a complete and continuing census of the uncared-for feebleminded of the whole state—this would state and define the problem. Many privately conducted surveys show the feasibility of such a census. The data for this census would be furnished by physicians, clinics, court and jail officials, social workers, town officials, teachers, etc. No doubtful case should be registered. Only those persons whose mental defect has been scientifically diagnosed should be registered. The register should be highly confidential and accessible only to properly accredited persons.

This coördination of existing records would be available for social workers, school authorities, and other agencies, and would be of enormous service in the solution of the individual problems which the feebleminded constantly present. This alone would mean a great saving in time, effort, and money. This official census would give a logical basis for intelligent management of the mental defectives of the state.

A census of the feebleminded would make possible and desirable some provision for a central governmental authority responsible for the general supervision and assistance and control of the uncared-for feebleminded of the state who do not need immediate institutional commitment. This state supervision of the feebleminded should be directed by a state commission for the feebleminded, or a properly constituted state board of health, or other similar body. Its responsible officer should be a psychiatrist, with special knowledge of mental deficiency and its many social expressions.

The local administration of this supervision could be carried out by the use of existing local public organizations, existing local private organizations and societies, or by properly qualified volunteers in each community. These peripheral workers could be made efficient by the use of suitable manuals, etc. This systematic supervision of the feebleminded could easily be made to cover the entire state, with a local representative in each community, but all under the direction of the central authority.

Each defective could be regularly visited and kept under observation by the local visitor. The reports of these visitors, covering the life histories and the family histories of many cases, would soon constitute an invaluable treasury of information as a basis for scientific research and study in the search for practical methods of prevention. The official visitor would advise the parents as to the care and management of the defective, and would have opportunity to inform the family, the local officials, and the community generally as to the hereditary nature and the peculiar dangers of feeblemindedness.

The registration of every feebleminded person, and the regular visitations, especially of children of school age, would make it possible to inform the parents of the condition of the child, of the probable necessity of lifelong supervision, and of the possible need for future segregation. Suitable, tactful literature should be prepared, which could be gradually presented to the parents in a way that would have great educational value. Sooner or later, the parents would probably be willing to allow their child to be cared for and trained in an institution if he needed such care. In suitable cases parents should be allowed to have the custody of their child, with the understanding that he shall be properly cared for and protected during his life, that he shall not be allowed to become immoral or criminal, and that he shall be prevented from parenthood. Whenever the parents or friends are unwilling or incapable of performing these duties, the law should provide that he shall be forcibly placed in an institution or otherwise safeguarded. The local representatives of the central bureau would officially serve as advisers and sponsors for pupils graduated from the special school classes, for court cases under probation and observation, and for institutional inmates at home on visit or on trial.

Under this plan there would be a person in every locality familiar with the opportunities for mental examination and methods of permanent commitment. The extra-institutional supervision and observation of cases in their homes would do away with the necessity of institutional care of many persons who would otherwise have to go to an institution, thus reducing the expense of buildings and maintenance.

There should be legal provision for the commitment of uncared-for defective persons to the permanent custody of the central authority. This commitment should formally recognize the actual mental age and degree of responsibility of the defective person so committed. The legal status of a defective should be that of a normal child with a mental age of eight, nine or ten years. The permanent eight- or nine- or ten-year mentality of the defective should be legally acknowledged.

The extra-institutional supervision should include cases dismissed from institutions, so that the defective who has spent many years in an institution would not be thrown out into the world with a freedom which he does not know how to utilize. In these cases, the supervision would constitute a permanent parole which would be most effective. This provision would enable the defective to be returned to the institution if he did not properly conduct himself in the community. Such provision for registration of the feebleminded and for extra-institutional supervision would insure that those defectives who most need institutional training and protection would be sent to the institutions, and that those who can live safely and happily in the community would be allowed to do so.

The keynote of a practical program for the management of mental defectiveness is to be found in the fact, which seems to have been proved, that those defectives whose defects are recognized while they are young children, and who receive proper care and training during their childhood, are, as a rule, not especially troublesome after they have been safely guided through the period of early adolescence.

Every child automatically comes under the control of the school authorities between the ages of six and fourteen. Every case of mental defect can be easily recognized during this period. Present methods of health examination of school children could easily be extended so as to insure and require a mental examination of every child obviously retarded in school accomplishment. It would not be necessary to give a mental examination to all the school children. It would be sufficient to examine only those children who are three or four or more years retarded in school work—perhaps 2 or 3 per cent of the primary-school population.

In the large cities, the mental examinations could be made by special examiners and at mental clinics. The rapid development of out-patient mental clinics all over the country will soon furnish facilities for such examinations in all the large cities. Rural communities and small towns could be served by a traveling mental clinic, as a part of the state government. This clinical group, or even a single clinician, could examine the presumably defective children over a very large area. A visit to each small town once each year would be sufficient. Every institutional school for the feebleminded should conduct out-patient mental clinics at the institution and in the various cities and towns served by the school. At the time of the mental examination, the parents should be informed as to the mental condition of the child and of his need for special training and protection.

Suitable manuals should be prepared by the state board of education, which could be placed in the hands of every teacher, especially in the rural schools, describing the methods of training and management that should be applied to these cases. It should be recognized that the defective child is entitled, even more than a normal child, to education according to his needs and capacity. The defective children who cannot be taught in the regular schools should be referred to the special classes or the institutional schools.

Cities and towns of over five thousand population are likely to have groups of at least ten or more defective children. Such communities should be required to establish special classes for defective children. The proper authorities should decide upon the courses of study and the equipment of school materials which are necessary for these special school classes. Provision should be made in the normal schools for training teachers of defective children. Every normal training school for teachers should be required to give suitable instruction to teachers, to enable them to recognize probable cases of mental defect and to give them a general idea as to the training and discipline of such children. The state board of education or some other branch of the state government should prepare simple manuals of facts for the use of the parents of feebleminded children. This literature should be prepared in series, with special articles for young boys, for young girls, for older boys, for older girls, and for other groups, and should kindly and tactfully instruct the parents as to the limitations of these children in the way of scholastic acquirements, and emphasize the importance of the development of habits of obedience and industry and the necessity of protection against evil influences and companions during the formative period, and of the possible need of institutional care in the future.

The great majority of mental defectives are of the moron group. If the plan suggested for the early recognition and the intelligent education and training of the moron in public schools and at home is carried out, many of this class can be safely cared for at home. We have begun to recognize the fact that there are good morons and bad morons, and that it is often possible in early life to recognize the moron with antisocial and criminalistic tendencies, who will probably need institutional care. Morons from families unable properly to protect and control their children will need institutional training and care. The fact should be emphasized that the neglected moron is the defective who makes trouble later in life, and that during the formative period of his life he should receive proper care and training either at home, with the special help of the regular teacher or the special class, or in an institutional school.

The special public-school classes also serve as clearing-houses for the recognition of defective children who are markedly antisocial and immoral, and who need permanent institutional care. It is an easy step from the special class to the institution. The children who graduate from the special school classes should have the benefit of follow-up or after-care assistance and help.

In the majority of states, the only provision for mental defectives is furnished by an institutional school for the feebleminded, providing care and protection for a limited number of idiots and imbeciles, education and industrial training for morons, with permanent segregation for a certain number of defectives, and with special emphasis upon the lifelong segregation of feebleminded women of the hereditary group. It was formerly believed that it was possible and desirable to provide institutional care for practically all the mental defectives of the state. This was before the actual extent of the problem was known and its cost computed, and before the difficulty of securing the commitment to an institution of many of these cases was realized. In practice it has been found very difficult to insure the lifelong segregation of the average moron. The courts are as ready to release the defective as they are to commit him in the first place. However proper and desirable it may be in theory to insure the lifelong institutional segregation of large numbers of the moron class, it is a fact that there is a deep-seated prejudice on the part of lawyers, judges, and legislators towards assuming in advance that every moron will necessarily and certainly misbehave to such an extent that he should be deprived of his liberty. That such misgivings are well-founded is apparently shown by the studies made of discharged patients at Rome and Waverley. At Waverley, a careful study of the discharges for twenty-five years showed that a very small proportion of the discharged male morons had committed crimes, or had married, or had become parents, or had failed to support themselves, or had been bad citizens.

It has been fairly well demonstrated that the average male moron, without naturally vicious tendencies, who has been properly trained in habits of obedience and industry, and who is protected from temptation and evil associations during his childhood, can be safely returned to the community when he has passed early adolescence, if his family are able to look after him and give him proper supervision. A very much larger proportion of these trained male defectives would be suitable for community life if the above-described extra-institutional control and supervision could be provided.

The average citizen is not yet convinced that he should be taxed to support permanently an individual who is capable of 30 or 50 or 70 per cent of normal economic efficiency, on the mere theory that he is more likely than a normal individual to become a social problem. Thousands of morons never give any trouble in the community.

The after-care studies of the female morons who have received training in the institutions were not so favorable, but many of these, too, led moral and harmless and useful lives after their return to the community. The study of discharged female cases at Waverley showed a surprisingly small number who became mothers or who married. While it is true that defectives with undesirable habits and tendencies are not easily controlled, it is equally true that defectives who are obedient and moral and industrious are apt to continue these traits permanently. It is as difficult for them to unlearn as it was to learn. Those defectives whose tendencies are such as to make them undesirable members of the community should not be allowed their liberty, but should be permanently segregated in institutions. No other class of human beings so surely avenge neglect in their childhood, socially, morally, economically, and eugenically.

Defectives who develop markedly immoral or criminalistic tendencies in the institutional schools for the feebleminded should not be retained permanently in the institutions devoted to the care and training of the average defective, for the feebleminded are most suggestible and easily influenced and should be protected from the companionship and influence of the defective with criminalistic tendencies. These "bad" defectives should be committed to and cared for in an institution especially for that type, where the discipline could be made more rigid, and permanent detention more certain.

If 25 per cent or more of the inmates of our penal and correctional institutions are feebleminded, as has been shown, it should be required that a mental examination should be made of all inmates of such institutions, and that those criminals who are found to be mentally defective should not be automatically discharged, to return to the community, but should be committed to a special institution for defective delinquents, and should be permanently segregated, and discharged only under the strictest sort of supervised parole. Provision should be made for the mental examination of all persons accused of crime when there is any suspicion as to the mentality of the accused.

There is no doubt that every state in the union needs greatly increased institutional facilities for the care of the feebleminded, not only as a matter of justice and fairness to the feebleminded themselves and to their families, but as an investment that would repay the cost many times over.

There is no panacea for feeblemindedness. There will always be mentally defective persons in the population of every state and country. All of our experience in dealing with the feebleminded indicates that if we are adequately to manage the individual defective, we must recognize his condition while he is a child, protect him from evil influences, train and educate him according to his capacity, make him industrially efficient, teach him to acquire correct habits of living, and, when he has reached adult life, continue to give him the friendly help and guidance he needs. These advantages should be accessible to every feebleminded person in the state. Most important of all, so far as possible, the hereditary class of defectives must not be allowed to perpetuate their decadent stock. The program for meeting the needs of these highly varied and heterogeneous groups must be as flexible and complex as the problem itself. It will be modified and developed as our knowledge and experience increase.

To sum up, the program now possible includes the mental examination of backward school children; the mental clinic; the traveling clinic; the special class; directed training of individual defectives in country schools; instruction of parents of defective children; after-care of special-class pupils; special training of teachers in normal schools; census and registration of the feebleminded; extra-institutional supervision of all uncared-for defectives in the community; selection of the defectives who most need segregation for institutional care; increased institutional facilities; parole for suitable institutionally-trained adult defectives; permanent segregation for those who need segregation; mental examinations of persons accused of crime and of all inmates of penal institutions; and long-continued segregation of defective delinquents in special institutions.

The above program would require team work on the part of psychiatrists, psychologists, teachers, normal schools, parents, social workers, institution officials, parole officers, court officials, prison officers, etc. There would be a highly centralized formulation of plans and methods and of authority, but much of the real work would be done in the local community. The degree of development of the program in a given state would depend upon existing knowledge and public sentiment on the subject in that state and this in turn would be measured by the wisdom and experience of the responsible officials. Nearly every suggestion in the proposed program is already being followed in some state. No one state has anything like a complete program.

DEMENTIA PRAECOX AS A SOCIAL PROBLEM

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IT has long been known that dementia-praecox patients constitute a large part of the chronic cases in state hospitals for mental disease, but it was something of a shock to learn, when the first census of the psychoses of the patients resident in the New York State hospitals was taken on July 1, 1916, that of the total patient population of 35,213, 18,940, or 53.81 per cent, were cases of dementia praecox. The census taken a year later showed that these cases had increased to 19,544; the percentage, however, had remained practically the same. The number of dementia-praecox first admissions to the civil hospitals during the fiscal year ending June 30, 1917, was 1,475, or 21.4 per cent of the total first admissions, and the number of deaths in the group was 852. Excluding transfers, there were 674 discharges and 469 readmissions. The total number of dementia-praecox cases under treatment during the year was 21,070.

These data give a glimpse of the magnitude of the problem, but they do not tell the whole story. Kirby and Bleuler have called attention to the fact that certain dementia-praecox cases develop without hallucinations or pronounced trends of any sort and, on account of the absence of psychotic symptoms, rarely reach the state hospitals, but become chronic loafers, beggars, tramps, and poorhouse inmates. The number of these useless human beings is not known, but the burdens they impose on society are exceedingly heavy.

The significance of the 19,544 institution cases of dementia praecox may be better seen by comparison with other wards of the state. On June 30, 1917, the number of prisoners resident in the five state prisons was 4,509; the number of feebleminded in state institutions was 3,461; the number of epileptics, not feebleminded or insane, cared for by the state was 1,466; and the number of all classes of inmates in the other state charitable institutions was 4,572. The combined population of the five state prisons and the eighteen state charitable institutions on that date was 14,008—or 5,536 less than the number of dementia-praecox cases in the civil state hospitals. If the dementia-praecox patients now in our state hospitals were removed, nine of the thirteen hospitals could be closed and the remaining four would have 752 less patients than at present. The net increase of dementia-praecox patients in our civil state hospitals last year was 614. If this rate of increase continues, as it probably will, a new institution of the size of the Middletown or Buffalo State Hospital will have to be built every three years to provide for this *one* class of patients alone.

In our recent statistical studies of the various psychoses, we have obtained a general view of dementia-praecox patients, so that we can now state some fairly positive facts concerning the group as a whole. With respect to age, we find that of every 100 dementia-praecox first admissions, 8 enter the hospital before reaching the age of 20 years, 43 enter between the ages of 20 and 30 years, and 30 between the ages of 30 and 40 years; the remaining 19 are 40 years of age or over at the time of admission. Marked differences appear between the ages of the male and of the female first admissions. Sixty per cent of the male cases and only 41 per cent of the female cases are under 30 years of age at the time of admission. Eighty-nine per cent of the males and 71 per cent of the females are under 40 years of age. The percentages of cases between the ages of 30 and 40 years are practically the same in both sexes. The fact that 49 per cent of the cases are 30 years of age or over at the time of admission shows that dementia praecox can not be considered as *insanity of youth* as the term implies.

The percentage of dementia-praecox first admissions with unfavorable family histories varies from year to year, but our statistical reports indicate that approximately 50 per cent of the ascertained cases have family histories of insanity, nervous diseases, alcoholism, or neuropathic or psychopathic traits. On the other hand, approximately 50 per cent of ascertained cases have no unfavorable family history.

With respect to original mental make-up, we find that 46 per cent of the ascertained cases are temperamentally normal; 54 per cent, temperamentally abnormal; 78 per cent, intellectually normal; and 22 per cent, intellectually abnormal. The temperamental peculiarities in some cases may be the beginnings of the disorder rather than an inherited defect.

Alcohol is an assigned etiological factor in approximately 4 per cent of the cases, and the intemperate use of liquor is reported in an additional 8 per cent. These percentages vary somewhat from year to year.

With respect to marital condition at the time of admission, we find that 65 per cent are single; 27 per cent, married; 4 per cent, widowed; and 4 per cent, divorced or separated. The males differ markedly from the females with respect to marital condition. Of the males alone, 79 per cent are single and 16 per cent, married; while of the females, 50 per cent are single and 38 per cent, married. The percentage of single patients among first admissions of all groups is 46, and of married 39. The failure of such a large proportion of these patients to marry would seem to indicate that dementia praecox is not, like feeblemindedness, a self-propagating defect condition.

With regard to school training, we find that 67 per cent of the dementia-praecox first admissions are reported as being of common-school grade; 7 per cent as having a high school education; and 1.3 per cent as having taken a college course. These percentages vary but slightly from those obtained for the first admissions of all groups.

With respect to economic condition, we learn that 17 per cent of the dementia-praecox first admissions are dependent; 83 per cent are self-supporting, 75 per cent being in marginal circumstances, and 8 per cent in comfortable circumstances. The percentages of dependent, marginal, and comfortable for all first admissions are 17, 71, and 12 respectively.

The dementia-praecox cases come principally from cities. In 1917 the percentage of urban first admissions was 92.5 and of rural, 7.5; while the per cent distribution of the general population of the state in 1910 was 78.8 and 21.2 respectively. The rate of dementia-praecox first admissions per 100,000 of the general population in 1917 was 17.3 in cities and 5.2 in rural districts.

With respect to occupation, we find that dementia-praecox patients come from all branches of industry, but the rate of incidence of the disorder varies greatly in different occupations. It is higher in indoor than in outdoor occupations, and in domestic and personal service than in other indoor occupations. The highest rate of incidence is found among servants and laborers. Many cases come, however, from manufacturing and mechanical industries, and from clerical and professional service. Of the 3,483 male dementia-praecox first admissions admitted to the civil state hospitals from October 1, 1909 to June 30, 1916, 96 came from the ranks of the professions: 18 were musicians; 16, draftsmen; 10, teachers; 7, artists; 6, lawyers; 4, dentists; and 3, physicians. There were no statisticians among them.

It is well known that the hospital treatment of dementia-praecox patients results in complete cure in but very few cases. Of the 21,070 cases under treatment in the civil state hospitals during the fiscal year of 1917, 21 were discharged as recovered; 247 as much improved; 272 as improved; and 134 as unimproved. It is probable that most of the cases discharged will return to the hospital. The total number discharged benefited by treatment equals approximately 28 per cent of the total dementia-praecox admissions of the year. In the other groups of psychoses the percentage was 41.5. Eight hundred and fifty-two dementia-praecox patients died in the hospital. The average age at death was 50 years. The death rate per 1,000 under treatment was 40.4. The average time spent in hospitals for the insane by the dementia-præcox patients who died was 16 years. This period is considerably longer than that spent by the average patient in any other clinical group. The general average period spent in hospitals by patients of all groups who died in the hospitals in 1917 was 6.3 years. The general average period of all patients other than dementia praecox was 3.5 years.

In treating dementia-praecox patients in the hospital, it is found that about half of the younger cases can be taught to do useful work and some become fairly efficient hospital workers. Besides instruction in industrial work, some physical training is given and a few accessible cases are helped by psychoanalysis. As the disorder is generally regarded as incurable the aim of treatment is to make the patient as useful and comfortable as possible and to prevent further deterioration.

Here, then, is our problem in the state of New York. We have 20,000 apparently hopeless dementia-praecox patients to be cared for at public expense for an average period of 16 years; 1,500 new cases are coming into the civil state hospitals each year, causing a net annual increase of 600. We do not know the fundamental causes of the disorder and we do not know how to cure or prevent it. What is to be done? I ask this question here [Conference, New York State Hospital Physicians] because the state is looking to us for an answer. Shall we be content to let the accumulation of these cases go on indefinitely? Shall we assume a pessimistic attitude and say that nothing can be done? Shall we wait until the problem is solved by some one else? Or shall we take up the problem and solve it ourselves? We have competent investigators, psychiatrists, pathologists, social workers, and statisticians who might jointly study this problem under the guidance of the director of the Psychiatric Institute. If more funds are needed, I am sure the state will supply them. A hundred thousand dollars a year might well be spent in learning how to prevent and cure a malady that now involves annual direct and indirect losses to the state of more than $10,000,000.

If some unknown physical disease should strike down and kill 1,000 young people in this city during the current year, do you think the medical profession, the newspapers, and the public generally would view the matter with complacency? Yet dementia praecox will come into this city [Brooklyn] as a masked enemy and steal away the minds of 1,000 young men and young women and condemn them to a living death during this year, 1918, and scarcely any public mention of the matter will be made.

Disease prevention is a comparatively new field of scientific endeavor, but within the past thirty years many virulent diseases have been conquered and the average span of human life has been greatly lengthened. Until recent years attempts to combat mental disease have been unavailing, but now great progress is being made in the elimination of the causes of alcoholic insanity and of general paralysis. Our victories in these fields should give us courage to undertake the much more difficult drive against our most insidious enemy, dementia praecox.

THE EXPERIMENT IN OCCUPATIONAL THERAPY AT BASE HOSPITAL 117, A. E. F.

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THE importance of the experiment in occupational therapy that was carried out at Base Hospital 117 at LaFauche lies in the fact that it was the first time that this form of treatment was put into effect in a military hospital under what must be considered forward-area conditions. In the early days of June, 1918, this hospital was in the advanced section of the S. O. S., about twenty-five miles from the front line. The further significance of the workshop in this hospital is associated with the kind of patients that were treated there. Base Hospital 117 was a special hospital planned to treat cases of war neuroses as soon as they could be taken there from the front lines. The character of the cases, and the fact that an attempt was made to treat them with all the methods that were in vogue in the best equipped hospitals in the back and in the home area, form the two striking features of the test that was to be given to a form of therapy which up to that time had been reserved for hospitals at base ports or for those forming a part of hospital centers or such hospitals as had the advantage of being in the environment of home conditions, where the problem of obtaining shop, tools, and workers was not present.

In describing the methods that were carried out there, it must not be forgotten that Base Hospital 117 had a particular problem to solve in a medical way and that the necessity for a proper solution of this problem was never permitted to escape the minds and interests of the medical and nursing staff or of the civilian aids who ran the workshop.

A case of war neurosis is generally a soldier who is in good physical condition—that is, who is organically sound. He is not wounded as a rule, and generally he has no evidence of disease in the ordinary meaning of the term. His physical fitness, then, gives him a certain potential value as a soldier. The thing that prevents him from being so is the fact that he has failed to adapt himself to the conditions that are before him as a result of a shock to his nervous system. This failure in military adaptation shows

Red Cross hut and occupational-therapy workshop of Base Hospital 117

Panoramic view of Base Hospital 117

Entrance to officers' chateau

itself in the form of one of the types of war neuroses. It is not necessary here to go into the mechanisms of the neuroses or to point out any of the symptoms, but merely to characterize the clinical problem from the point of view of the attack to be made upon it by the method of occupational therapy.

A part of the definite problem that these cases presented was due to the fact that it was of prime importance to cure these patients as promptly as possible and to return them to duty in front-line work if possible, or at least to some active participation in the fighting area. This was necessary for two reasons: first, the leakage through an increase in the number of war neuroses would become serious from the point of view of morale and man power and, second, the physically fit must be considered as the best possible material for replacements or return to the lines. The therapeutic problem in general was focused upon these simple considerations and in the occupational phase of it the same ends had to be kept constantly in view. Never before, perhaps, had a form of treatment to undergo so severe a test and pass through its test under such primitive and difficult conditions. That the work therapy and the aids who conducted the shop succeeded means that the principle of the efficacy of work in the treatment of the neuroses, of the war type at any rate, has been established. A method of treatment that can meet its purpose so surely and definitely as this did would seem to have something of the adaptability of a proven thing. Conditions of actual warfare form the most severe test of any method of treatment, and if a method comes through the test, proving itself serviceable and adaptable, then it becomes a necessary routine for the same sort of condition met with in any kind of environment.

Occupational therapy previous to the war was looked upon as a kind of luxury in a hospital able to afford unessential things of that sort. It was approved, as a rule, in institutions for the insane because it had its origin there in the use of manual labor on the part of the patients in various types of agricultural tasks. It grew, therefore, from a beginning that showed its practical success both in the effect on the patients and in the influence it had on the visitors. The products of the garden and the field made a ready appeal to the boards that controlled the policy of the institutions. There has never been much objection to the introduction of the principle of occupational therapeutics in institutions for the treatment of the insane. In other places the notion of work as a well defined and logical method of treatment has had a difficult time of it, and it is only recently that its recognition has come from all sides.

The principles that guide the use of occupational therapy are in process of being established, gathered together from the various experiences in which this method of treatment has shown its adaptability and its utility. In the treatment of the neuroses it has found its chief application, and in the war neuroses especially it has developed almost into a routine. The utilization of occupational therapy in some of the more advanced sanatoria in the United States is, of course, well known, and the work of Dr. Hall in Marblehead in this connection needs only to be mentioned. It is not necessary to recall to mind other places where recognition has been given to this form of treatment, or to note that work as a method of treatment in the neuroses is not a new idea. Many years ago, Grohmann, a Swiss engineer, in an institution in that country, developed the technique, and very little, so far as general application is concerned, can be added to his work. What is new, however, is the use of a workshop in a forward-area hospital, under conditions found in an army hospital, in the treatment of acute cases of war neuroses.

In Base Hospital 117 the use of work as a curative agency sprang in the first place from the necessities of the hospital in the early phase of its development. Before the regular staff had arrived and before the equipment had been brought over, when the hospital was simply an old field hospital with a few wards and a few medical officers, it received about fifty cases of what were afterwards called anticipation neuroses. These were soldiers who had never seen active service and had never been anywhere near the front lines, but had developed their neuroses either in America before sailing or en route to France. They presented a very unfavorable type of case, as may well be imagined. They were not war neuroses in the real sense of the term, never having been exposed to the traumata of warfare, but they presented symptomatically all the evidence of the most severe types of this condition. Treatment was extremely difficult because there was little either in temperament or make-up to build upon. They represented as a whole the so-called neuropathic types of soldiers, the kind that were not at all adapted to the conditions of warfare. They would have been excluded from the army if at that time there had been in force the methods of elimination adopted later.

The hospital was much handicapped on account of the lack of roads and pathways between the rows of huts. It had been laid down on a field, and the wet and rainy winter had left it in a condition that prevented traffic of almost any kind through it. The first essential, then, was to build a road through the hospital connecting with the well-made French road leading from the highway to the village of LaFauche. Patients of all sorts were put to work breaking up stone and carrying it to make a foundation for a macadam road. The use of the stone-breaking hammer and the carting of the stone to the roadbed employed these patients for a number of weeks until the road was completed some time in May. The road was a model in its way and showed its value when the hospital grew to its largest capacity of some twelve hundred beds.

There was, of course, in this use of occupational therapy none of the refinements that were afterwards developed, and no attempt was then made to emphasize the localization of therapeutic effort. It was occupation therapy in the broadest sense, and it had its effect on the patients simply because it gave them something to do and showed to those with paralyses and tremors that it was possible for them to carry out coördinated movements and to make use of their muscles in the production of tangible results. From this very crude beginning the therapeutic workshop, when it arrived for duty, found that the principle of work had been already established. The value to the individual patient was difficult to establish, as with this class little in the way of permanent improvement could be expected. Some of them did show rather good effects, and it was interesting to note that very few of them objected to this rather monotonous and tiresome form of work. The breaking of stone gives a good deal of opportunity to train coördination, and the use of a certain amount of skill is necessary in order to prevent injury to the hand holding the stone to be broken. The evidence of effort could be measured by the increasing pile of material, and the fact that this work was supplying a very practical need, of which the finished portion of the road was the witness, formed the essential elements upon which the efficacy of any work scheme in treatment is based. It accentuated further the fact that the type and kind of work are not of importance, nor is the output, either in quantity or quality, significant. The things that count, however, are the physiological and psychological features that result from effort to overcome resistance. The crude and primitive employment of breaking into smaller fragments a bit of stone in order to build a road may be taken as an example upon which to base the principles of a work therapy on a more extensive scale. The very primitiveness of the instruments used and the use of the product suggests that something inherently deep down in man's make-up is touched in this performance. Road making is an ancient calling no doubt, and the soldier responded to this as he perhaps might not have to a more intricate job.

The point is that in its therapeutic effect work is based upon very simple elements and that these simple elements should always be thought of in planning an individual application. If the performance of breaking rock for the making of a road is examined, it will be found that certain necessary elements enter into it, and if a more intricate kind of work is studied, it, too, will be found to represent only modifications of these very primitive elements. If a problem of work therapy is studied as far as the neuroses are concerned, there appear certain requirements that must be met. These features are of two kinds—one is primarily mental or psychological; the other is physiological or mechanical. These features apply also to the two sorts of individuals with war neuroses that benefit from the work treatment. One needs it because there is some defect in coördination in a broad sense, and the other because there is some psychological readjustment that demands attention. The exercise in coördination is found in the precision that is essential in using the hammer and in carrying out the necessary maneuvres in preparing and in handling the crude material. There is added to this an additional element that tends to produce precision of motion, and that is the danger of hurting the hand if the blow is not struck right. This makes for concentration and attention and brings into play the use of the eye at first to a great extent, and then develops an automaticity of movement that overcomes the excessive muscular activity that is associated with tremors and ataxic conditions. The development of strength that is muscular power comes with the practice necessary to perform a definite task. There is, too, a certain amount of noise associated with breaking stones, which was found to be a benefit to such cases as complained of being sensitive to sounds. This had to be overcome, and it was often found that the sound of the hammer against the stone was the best method of training this type of case to the usual hospital noises. The evidence of the productivity of effort could be measured by the pile of stone that grew up by each patient. The evidence of utility was the road itself, which the patient saw slowly grow under his eyes. The psychological phase of this kind of work was found in the proof to the patient that a defect in muscular power must be only an evanescent one if a muscle group that is not acting right is capable of carrying out effectively so complicated a type of movement as handling a hammer. The evidence of sufficient muscular strength was there to be seen. The conviction was forced upon the patient, therefore, that his defect was not only a temporary one, but that it was easily curable by the simplest of procedure—that is, use. The emotionally overloaded state that so many of these patients were in could be most easily lightened by giving them a muscular outlet or rather an effort outlet. Through their hands and fingers, the emotional hypertension was sidetracked or exploded. In such routine work as this, automatic as it became afterwards in most instances, there was given to the patient an opportunity to face his own experiences if he had any or to face his present situation as it was interpreted to him by his medical officer. He could use his intelligence at the same time that he was carrying on his task.

This feature of this kind of employment therapy was used effectually in the material that came to the hospital later, when the more definite types of war neuroses, fresh from the combatant area, arrived.

The emphasis on this simple type of work therapy is given because it underlies so much of the philosophy of occupational therapy and it opens the way for the proper appreciation of just what can be expected from treatment in the more exacting sorts of work that were afterwards used. What was lacking, of course, was the effect of the shop spirit as a whole that may be developed in a well-organized shop, and the personal effect on the patient of a skillful aid or teacher. These elements can be supplied only in a shop and by the presence in that shop of trained workers.

In the month of June the arrival of the complete staff at La-Fauche and the increase in the number of available beds brought the hospital face to face with the duty it had been organized to carry out. Numbers of patients began to come, many of them showing the most severe symptoms of the war neuroses and many of them comparatively fresh from the active fighting areas. The therapeutic problem was focused in the attempt to cure these patients as promptly as possible and to return as high a proportion as possible to active duty. From this time until the end of the war, some 3,000 cases of war neuroses passed through the hospital, and a large proportion took part in some kind of work during their stay or passed through the workshop as part of their treatment. It was possible to judge, therefore, with a fair approach to accuracy, just what work in this sense was able to do for them and how necessary a part of a hospital for the neuroses a workshop may be.

There arrived with the Unit a group of civilian workers who took the task of running the workshop in their hands, and thus the extra-medical therapy became an established thing in this hospital and was part of the routine of treatment which every patient might receive if his medical officer so desired.

Owing to lack of room, the workshop was set up at first in an unused part of a hut that had been a storeroom. A few tables were found; benches were made by the carpenter, one of the civilian aids; and in a few hours patients had been assigned to the shop for treatment. Some weeks later a special Red Cross hut was furnished to the hospital, and here were established the permanent quarters of the shop, with increased facilities which seemed to most of us very wonderful equipment considering the difficulties in the way of transportation and supply.

The evolution in work therapy from that of stone breaking and road building to the craftmanship that soon developed in the shop was a surprising and interesting thing. The shop, as a shop, began to have an influence on the patients in addition to the individual therapeutic effect of a specialized kind of work. It soon became a place where patients liked to be sent, and in its busy atmosphere of things being done many a patient passed hours during which he felt little of the burden which his condition otherwise would have produced. During the whole period of the hospital's existence, other types of work were continued, not only as a therapeutic method, but because the hospital could not have functioned without them. The policing of the hospital in the military meaning of the term—which is the cleaning up in the wards, kitchens, pathways, etc.—was practically done by the patients, and the road was kept in repair by them. Wood chopping and the cultivation of the farm land surrounding the hospital were always considered a part of the duty of patients, and they were told that in doing these things they were carrying out in a practical way the prescription of the physicians who were treating

Courtyard of officers' chateau

Another view of the chateau

Staff club house

them. About 85 per cent of the total sick population of the hospital was always engaged in work of some kind, and most of it was done through the prescription of the medical officers in charge of the various wards.

The workshop was considered as a sort of specialized therapy directed to a more definite end, planned to treat some definite symptom or to meet some special indication, while the other kinds of work were regarded as a kind of therapeutic background underlying the whole scheme of curative effort.

A patient was kept in bed for only the shortest time possible and generally after a day or two of rest to give opportunity for a satisfactory examination, and if no intercurrent illness or other defect were found, he was ready for some kind of work, either of the general sort or in the workshop itself. There was thus given an opportunity to study the effect of work as a whole upon this class of patients in a material that was completely in control of the medical staff and that represented the same kind of condition throughout. A controlled and known large group of patients suffering from functional disease of the nervous system caused by the varying traumata of warfare was in this way made the measure and test of a method of treatment which was applied, as any method of therapy should be, according to the individual needs of each patient.

The principles of application were very simple and were based largely on the observations in the rock breaking and road building previously mentioned. The physiological and psychological needs were met by the use of muscular effort in the production of tangible articles. The handling of tools and the various movements of sawing, nailing, screwing, and hammering, and the finer and more coördinated movements of wood carving, metal work of various kinds, weaving, and tinning, as well as the much more delicate and much more emotionally inspired technique of painting, sketching, and printing, supplied the essential training that the paralysis, tremors, and choreiform symptoms needed. In a sense, all of these defects were due to an intricate psychological process in which dissociation of function was the predominant mechanism. The patient could not properly innervate a muscle group because there was a defect in the proper utilization of that group. The result was often overexaggerated movements in which the inhibitive control and the habituated minimum of effort were lacking. In the same way tremors were primarily defects in motor control, as were purposeless and ataxic movements of the choreiform types.

Motor reëducation, at first conscious and then automatically carried out, was required. The handling of tools awakened the dormant muscle control, shocked out of consciousness for the time being, and tended to restore the normal and habitual pathways long ago acquired. The familiar grip of a chisel, the friendly feel of a hammer or a saw, reëstablished the proper integration and the proper tonal balance in antagonistic muscle groups. These, as symptoms, were acting without any physiological law or purpose. The product that was being worked at gave the necessary interest and permitted the proper concentration, so that the movements were allowed to fix themselves in the proper channels and the emotional block which stood in the way was for the time being lost sight of and the individual used his hands much in the way that was customary with him. The evidence that this was possible was before him, an evidence that no amount of persuasion or explanation alone could at times accomplish. It must not be forgotten that a large proportion of American soldiers had used tools and implements before in their civilian life, and the traditional pathways, so to speak, were present and only temporarily out of action as a result of their condition.

Something must of course be said about the product that was turned out in this shop. The illustrations show a number of interesting things in the way of toys and models, but they cannot show the silver and copper work and the various things that were produced in the tin shop or the chief products of the carpenter shop. In the latter were made chairs, benches, and all other pieces of furniture that were needed in the wards and the offices of the hospital. Filing desks and cabinets and other things of that sort were turned out as the needs of the hospital grew. It seemed that the kind of thing worked at was of no real importance and that a patient was as interested in one kind of thing as in another.

No effort was made to select the kind of work from any other point of view than that of the immediate requirement in muscle defect that was present. The novelty of producing something that the patient had perchance never thought of doing himself lent an added interest to the carrying out of the job, but further than this no special effort was made to get up any unusual interest in the thing itself. There was in this way a certain lack of rigidity in the shops that was one of its main features. Patients were sent there not to be amused or to pass the time away, but to be cured; often the therapy was directed to the local defect of the patient and the effort was planned for that symptom and for nothing else. To some of the patients the workshop was a place where they were exposed to a more invigorating influence than was present in the ward. This was particularly so in cases of depression and of apathy, and likewise in those cases in which the prominent symptom was amnesia. In such cases the type of work and the product were of no importance whatever, nor was there a question of muscle training or education. Here the attempt was made to reassociate the separated bits of the patient's memory stream, and the stay in the shop was an extension of the effort of reassociation carried out in the medical treatment rooms by the several methods used in the hospital. The social element in the mingling with men and the doing of bits of accustomed things, the talk and the noise of a shop, the familiar surroundings, all helped to that end. The automatic arousing of interest in the things that went on about him was an important element in the restoration of the patient to his normal condition.

It must be appreciated that, as far as the workshop itself was concerned, there was no attempt made there to carry out any other form of therapy than that implied in the process of work itself. In fact, the aids were instructed to the effect that a shop was no place for developing theories of psychological treatment other than such as were naturally associated with the job at hand. The reason for this was that work in the sense in which it was used at LaFauche was primarily an objective type of treatment, and the patient was regarded as deficient in that particular respect which his definite symptoms showed. This point is of some importance because there is a marked tendency to complicate the physiological principles of work therapy with a lot of mysterious notions with respect to the influence of the personality of the instructors, the more or less artistic aspect of work in the matter of the production of beautiful things, and other aspects of the question which should not enter into consideration at all.

The fact that a soldier is put upon some piece of work that has an artistic quality in no important way divorces that exercise from the immediate object for which it is devised and that is the curing of a very tangible and evident defect. It is of little material value whether or not the patient obtains pleasure from the exercise, or whether or not it awakens in him some dormant artistic impulse. The grim aspect of war must always be kept in the foreground, and the soldier must always feel the necessity of getting well as quickly as possible so that he can take his place again in the fighting line. This latter idea has no artistic feature at all and has nothing to do with the production of beautiful things. Of course this refers only to the task that confronts a war hospital. In civilian workshops connected with hospitals a different attitude in this respect may be perfectly admissible.

A good deal of useless sentiment has been attached to the idea of work in a therapeutic sense, and it was difficult at times to keep the atmosphere of the shop at LaFauche free from it, especially as it came to be a much visited place and there was a tendency to regard the quality of the output as of primary consequence.

It is a question whether any display of products is wise; perhaps it may even be a good thing to destroy the article after it has served its purpose in helping cure the soldier. At least, if this is not done, constant care must be taken to avoid emphasizing anything but the direct physiological aspect of work. An exception to this general principle may be found in one type of case which is now and then found in a large group of war neuroses. If there is present in any severe case a capacity for self-expression in sketching or painting, and if this expression can be carried out with a certain facility, then this tendency may be used to complete a part of the treatment that is being carried on outside the shop.

The facing of the situation, a method which implies that the patient is told not to forget, but to remember past experiences and thus learn to compromise with them instead of dodging them, may be most successfully worked out if the patient is set to sketching or drawing the details of his experiences in the front lines, particularly those that preceded or accompanied the occasion when he was shocked or traumatized.

A number of such instances were found in the material at LaFauche, and the therapeutic result was very encouraging. These patients soon learned that it was the turning of their emotionally ladened memories of terrifying experiences into pictures and sketches that gave them a definite feeling of relief, and that there was nothing in this kind of exercise that was at all in opposition to the work therapy. It was only a different way of arriving at the same result that was sought each day in their interviews with the medical officers who treated them. Of course these drawings had a definite meaning and significance and they needed no interpretative mechanism to render them clear and distinct. As a contrast are the artistic productions of the insane, which are so often symbolically expressed and which act so often as a screen to the real meaning.

Whatever the psychical mechanism may be and whatever the place that emotion in relation to events may have, it is true that emotional states are relieved by muscular expression if this expression is tangibly directed by the patient. In this truth lies undoubtedly one of the great therapeutic agencies in work.

If the workshop in connection with a hospital, whether a military one or not, is to fulfill its largest duty, it must be regarded as a definite part of the medical organization. The patients that are sent there must always remain under medical supervision, and the treatment must be followed out by the physician who prescribes it and who has set the indication for its use. The workshop must be included, therefore, in the daily medical visit, and the patient's progress or failure to improve must be noted from day to day. It was the custom at LaFauche for the medical director to see the workshop daily, and the various ward physicians were asked to follow their patients through the shop as a necessary part of their medical duty. In this way wrong assignments to work of a particular kind would be discovered and the general reaction of patients to the tasks set for them could be determined. The most definite effect, however, was the emphasis that was placed on the purely medical aspect of the shop, and the assurance that it gave to the patients there that they were being treated for their disability in the shop just as much as they were in the wards.

Every effort was made—and, it must be confessed, sometimes without success—to combat the idea that the workshop was a sentimental adjunct to the usual routine of a military hospital close enough to the front areas to share in some of its grimness and war atmosphere. The presence of the civilian workers sometimes gave the impression, to the casual visitor at any rate, that that part of the hospital lacked some of the spirit of earnestness and grim determination that was typical of the rest of the hospital in its therapeutic activities. This was in no way the fault of the shop instructors, but the idea of a workshop was so new that it was difficult to convince some of those who saw it in operation that work therapy differed in no essential way from any other kind of treatment, and that it was just as direct and as carefully planned to meet and combat a symptom as an orthopedic apparatus to correct a deformity. The civilian aids, all of them, soon acquired the correct idea, and they shared with other members of the hospital staff the purpose and aim of all treatment in this hospital, which was to cure the patient so that he might go back to his division and do his share in fighting the Germans. The insistence on the purpose of the hospital is emphasized because it is necessary to reduce to its simplest form both the problem and the measures for its solution, in order to appreciate and to measure what was accomplished. To get at the primary principles by this kind of observation permits of an extension of its utility under less difficult and more elastic surroundings.

In civilian hospitals there is no need to keep in mind the immediate task confronting a patient, and there is certainly no particular advantage in insisting that he return to the environment that caused him to be a patient. Quite the opposite may be the proper thing to do. On the other hand, the therapeutic aim must be kept in the foreground, and the patient must realize that occupation is primarily a method of cure, not a pastime and not a thing to which he can afford to be indifferent. It is necessary also that this idea be shared by the physician who prescribes work therapy and by the instructors who carry out the prescription. In the intermediate territory where vocational training and occupational therapy closely touch, the importance of this attitude is easily appreciated. A military hospital serves its chief purpose in returning a sick or wounded or neurosis patient to military duty. There is no choice and no alleviation to this hard necessity. The very thing and the very circumstances that caused the disability are precisely those to which the soldier must be sent back as soon as he is cured. In this way a military hospital plays its silent and unromantic part in the grim and ugly game of war.

In a civilian hospital an opportunity is given to make of the patient a better type of worker, a more efficient citizen, by modifications in his environment or by training him to do things in a better way. Perhaps it will be possible in some future development of the shop idea to add to his educational assets, to give him a broader outlook, to make him see the economic and industrial conflict from a broader point of view. The possibilities seem to be without limit, and they have been scarcely touched in our present hospital method.

All such impulses will be without avail unless the working out

A patient weaving

Toys made by officer patients

of the plan is filled with a spirit of incisiveness and with a definite conception of what the whole thing means, and is completely divorced from the amateur spirit and from the attitude of dilettanteism which it is so difficult to keep out of extra-medical therapeutics.

The experience at LaFauche has shown the possibilities of work therapy under difficult and adverse circumstances and in primitive conditions. It has proved the efficacy of this treatment as an adjunct to other methods in a material that is commonly regarded as difficult to treat and more difficult to restore to military duty. Under all sorts of tests and with all types of war neuroses, occupational therapy has shown its value. The testimony has been so convincing that no hospital in war or peace that pretends to treat neuroses can afford to be without its occupational workshop. There remains, then, to put into the treatment of the civilian neuroses something of the spirit that animated the nurses, the civilian aids, and the medical staff at Base Hospital 117. That spirit was made up of understanding, enthusiasm, and a definite conception of the purpose that placed the hospital in the foothills of the Vosges Mountains.

DISCIPLINARY PROBLEMS OF THE ARMY*

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IT has been for some time a well-recognized principle among public-welfare workers that delinquency and crime have certain aspects that make a psychiatric or psychopathological inquiry in each case almost a necessity. This work, which has been so firmly founded by the pioneer work in this country of Doctor William Healy, Doctor Goddard, Doctor Glueck, Doctor Guy G. Fernald, and others, has nevertheless not received the attention and the public assistance that are required to put it on a more permanent footing. In spite of the work that has been carried on in the juvenile courts of Chicago and Boston by Doctor Healy, and by Doctor Guy Fernald at Massachusetts State Reformatory, as well as that of the Psychiatric Clinic at Sing Sing under Doctor Glueck, such work is still regarded by many as somewhat of a luxury, though perhaps a desirable one, in penal institutions. It is very encouraging to know that this work belongs to a group of enterprises that in the ordinary times of peace have had a rough road, but that as a result of the emergency demands of the war are gradually coming into their own.

The military establishment of the United States could not ordinarily be considered a likely place in which to find important work of this sort being carried on. The popular conception of military discipline is such as to preclude much expectation of finding welfare work and personal service regarded as of sufficient importance to require special or elaborate arrangements. Nevertheless, the military establishment has not only given consideration to this important field, but has actually exceeded the rather modest requests of the workers.

I am fortunate in having had some personal acquaintance with the disciplinary work of the army and in having this opportunity to bring before the Conference some of the results of the work of the Neuropsychiatric Section of the Surgeon General's Office in connection with disciplinary cases. Under the far-sighted leadership of General Crowder, Judge Advocate General of the Army, a constructive program of development of the disciplinary service, beginning in 1909, has been put into effect. As a first step in this connection the name of the institution at Fort Leavenworth was changed from the Military Prison to the United States Disciplinary Barracks. This clearly indicates the policy adopted by General Crowder—that punishment and the infliction of suffering were to be replaced by training and education and attempts at rehabilitation, whether in the army or in the civil community.

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* Read as part of a symposium on Disciplinary Problems before the Mental Hygiene Section of the National Conference of Social Work, Atlantic City, June 7, 1919. The other papers in the symposium were *Mental Disease and Delinquency*, by Dr. V. V. Anderson, MENTAL HYGIENE, Vol. III, No. 2, pp. 177-198; and *Disciplinary Problems of the Navy*, which is published in this number.

In ordinary times the United States Disciplinary Barracks at Fort Leavenworth had about 1,700 prisoners; the Atlantic branch on Governors Island had about 250, with a capacity of about 500; the Pacific branch on Alcotta Island, San Francisco Harbor, contained about the same number as the Atlantic branch, with a capacity of 500. The Disciplinary Barracks at Fort Leavenworth are located on a large military reservation and have been developed into an industrial training school where some seventy-eight trades are taught. It is unnecessary to describe the Barracks at this time, as most of those present no doubt took the opportunity at last year's conference at Kansas City to visit the Disciplinary Barracks. They will remember the very beautiful farm, the active shops, the large and airy cell buildings, and the barracks and exhibition drill of the disciplinary battalion. They will recall that the main building of modern fire-proof construction was erected at a cost of a little over $700,000, entirely by prison labor, with a saving of almost $2,000,000 to the government.

Since the meeting at Kansas City, certain things have occurred at the Barracks which have been reported, with more or less bias for or against, in the newspapers, and which have caused welfare workers throughout the country to doubt whether the efficiency of the Barracks was all that it appeared to be or that had been claimed for it. It might, therefore, be of interest to detail some of the causes for this in the light of work that has been carried on at the Barracks during the troubled times just past.*

In the first place, it will cause no surprise among you when you are told that one of the first effects of the war upon the Disciplinary Barracks at Fort Leavenworth was the withdrawal of nearly all the competent officers and guards. The trained guards were replaced by limited-service men, mostly from neighboring cantonments, and, with the stopping of recruiting, it was impossible to secure help. It was with great difficulty that the commandant succeeded in retaining the services of a handful of trained, competent officers, in view of the great need for them on more active military duty. So great was the need for trained officers that even the large addition of reserve officers, among whom could be found numerous individuals of great value to this work, could not be drawn upon. To make the situation still more difficult, the expected increase in the number of prisoners soon began to become evident. Instead of a normal population of 1,700, there were, in July 1918, 2,400 prisoners; by December 1918 this had increased to 3,600; by February 1919 it almost touched the 4,000 mark. Even this, however, would not have produced insurmountable difficulties had the population been of the sort that the Barracks were designed for, but a situation was created which presented almost an insoluble problem when, in the course of a few months, a group of some 500 conscientious objectors of various sorts were concentrated at the Barracks as military prisoners.

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*The opinions here expressed are the opinions of the writer on some controverted points and do not in any way represent the official opinions of the War Department.

It is not necessary here to go into the problem of the conscientious objector, or to take the time to discuss what might have been done, excepting in so far as the experience may have taught us what to do and what not to do in such or similar situations in the future. And by this we need not understand that these lessons apply only to the eventuality of another war. The problems and the difficulties in the disciplinary service of the United States Army are problems and difficulties that are with the community at all times—in peace or in war—and the methods that work in the one will work in the other.

The conscientious objectors, as is well known now as a result of the publicity that they have had, and especially as set forth in the book by Major Kellogg, represent a heterogeneous group of men. They had only one thing in common—namely, their resistance to the selective-service act and their unwillingness to bear arms. The reasons, the underlying motives, the previous experiences and training, the advantages or difficulties of each individual's career that lay back of the stand he took are almost as many as there are individuals in the group. With few exceptions, these men had committed no real delinquency, but were only technically law breakers. It is natural that their attitude towards confinement in a correctional institution should be quite different from that of the ordinary man sentenced there, who, however much he may extenuate his case, must have some realization of the reasonableness of his confinement. The second point of importance here was that in general this group was in education and intelligence equal to the average unit in the army or in the community and in numerous instances far superior. As a result there were among this group a number of very able leaders who, by skillful agitation and by perseverance, were able to coördinate the various motives and activities, not only of their own group, but of the prison population as a whole, with the result that soon the entire body of prisoners was in a sense organized for offensive and defensive purposes.

You have probably all read the report of the culmination of these tendencies and activities in the strike of last winter. This report, which was published in the *Survey*, was written by Mr. Winthrop D. Lane, who was present during the entire affair. Owing to the very far-sighted and fair attitude of the commandant, in which he had the support, not only of the competent officers of the Barracks, but also of the commanding officers of the post and of the infantry regiments stationed at Fort Leavenworth, this critical situation, fraught with all sorts of danger, not only to the institution, but perhaps even to the democracy of the country as a whole, was converted into a distinct gain in prison management. Representative government was reëstablished after a discontinuance of some years at the Barracks and under conditions which had the appearance of making it impossible under military law in time of war.

Crude as is this beginning at a coöperative management of penal and correctional institutions, it has been, on the whole, eminently successful and is still functioning with benefit to the prisoners and the institution alike, in spite of many recurring obstacles which are thrown in its way by hasty and injudicious acts on the part of uniformed officers without sufficient previous experience and training in this work.

The one thing which has contributed more than any other, perhaps, to the prevention of the more serious dangers and difficulties, and which offers most hope for the future, has been the work of the neuropsychiatric officers in connection with this institution. With all due allowance for mistakes and lack of skill, which are evident in the work of some of these officers, it can yet be maintained that had there been no department of psychiatry and neurology at the Disciplinary Barracks, and had the system originally devised by Colonel Rice and Lieutenant Colonel Edgar King, and greatly developed as a result of the constructive leadership of Colonel Pearce Bailey and the Neuropsychiatric Section of the Surgeon General's Office, not been so firmly established, the results might have been far otherwise than they turned out to be and might even have ended in real disaster.

At the United States Disciplinary Barracks the work of the neuropsychiatric department is not confined, as it has been in some of the civil institutions where it has been used, to the detection of gross mental abnormality. On the contrary, it has been coördinated with every activity in the Barracks. Each prisoner is regarded as an individual human being, and a personality survey is essential before any program is outlined for the prisoner. At every change that is made in his treatment, whether it is the granting of privileges, transfer to other living conditions, employment, education, release, reinstatement in the army, the neuropsychiatric officers are first called upon to examine into the facts and to make recommendations based upon the tendencies and the requirements of the individual prisoner. Many mistakes have been made in this, and as a result, no doubt, justice has not always been meted out; but taken as a whole the work of these officers has justified itself in view of the fact that the Barracks have been able somehow to weather the storm of the war and all the bad conditions suggested above.

In the course of last winter, a special survey of the institution was made as part of the training course given to psychiatric officers in disciplinary work under the direction of the Neuropsychiatric Section of the Surgeon General's Office. The results of this survey are of some interest in connection with the penal and correctional problem as a whole.

Before speaking of these results, it may be well to know that, large as was the prison population, it was very much smaller than was anticipated. At the outbreak of the war, the commandant, in reply to a request from Washington, made an estimate based on the figures for the Civil War, for the Spanish-American War, and for the operations on the Mexican Border, as a result of which he reported that an army of 3,000,000 men would require provision for about 50,000 prisoners at the Disciplinary Barracks. Instead of 50,000, the Disciplinary Barracks, including the two branches, received about 5,000 prisoners—in other words, 10 per cent of the estimated number based on previous experiences.

This can be explained on only two grounds: first, the enforcement of prohibition in the army in general and especially in cantonments and their neighborhood; second, the elimination, through the work of the neuropsychiatric officers, of low-grade defectives, insane, and psychopathic men at cantonments and recruiting stations. It was not very astonishing, therefore, to find, when the survey was made, that the distribution of intelligence among the prisoners examined, which included about 3,500 men, was practically that of the ordinary division of troops. There was an absence of the high proportion of defectives and psychopaths found in nearly all of our civil prisons. Instead of the 30 or 40 per cent of feebleminded and psychopaths found in the latter institutions, between 10 and 12 per cent were found among the prison population at Fort Leavenworth.

It was found that there was a correlation between education and intelligence. The educational median of the entire group fell in the seventh grammar-school grade. The men in the disciplinary battalion were, on the whole, rated higher both in intelligence and education than the general average. The religious and political conscientious objectors were the best educated of all the prisoners and had the highest intelligence rating. The men convicted of sex crimes and crimes of violence had less education than most of the other groups and were rated lower in intelligence. The men convicted of acquisitive crimes had more education than the average and a higher intelligence rating than any other group except the religious and political conscientious objectors. The conscientious objectors of the alien-enemy and non-citizen group were very low as to education and intelligence rating; a third had no schooling at all and half of them did not get beyond the third grade.

An analysis of the personality reactions of the prisoners was made, dividing the prisoners according to their findings into three general groups: (1) those who had been in difficulty as a result of lack of intelligence or judgment or because of some other marked mental defect; (2) those who showed no decisive defect, but whose difficulties, either in the army or previously, could be traced back to emotional instability either in the direction of violent temper or loss of control or of discouragement and depression; (3) those whose difficulties could be traced to a marked egocentric characteristic or trait.

With the cases classified in this way, it was found that 66 per cent of them fell into the egocentric group, 24 per cent into the inadequate group, and 6 per cent into the emotionally unstable group. The small number of the emotionally unstable group can be explained by the fact that as a rule delinquents of this sort arouse the sympathy of their fellow men, and the experience of the Disciplinary Barracks corresponds to that of civil institutions to the effect that these individuals are rarely sentenced to confinement, but are released at some point in the chain of events previous to commitment.

The inadequate group includes the feebleminded and low-grade cases that had passed through the elimination of the neuropsychiatric officers at camps or had been sentenced before the neuropsychiatric work had become established. With the elimination or reduction in numbers of the insane or feebleminded cases, there remained the large group of egocentric individuals who probably represent the principal part of what may be justly termed the penal problem. The egocentric type of person, who is rather intolerant and set on his own point of view, insistent on his rights, ready to be offended and injured and always uncompromising, may be associated with any other ability or disability that the human personality is capable of. The group includes not only every sort of delinquency recorded at the Barracks, but also a large proportion of the higher-grade conscientious objectors.

No attempt is made by the neuropsychiatric officer to pass on the social value of this type of personality. It must be obvious to every one that the egocentric trend in itself is not an undesirable feature—that in many instances it is nothing more than another name for what we ordinarily term ambition. Furthermore, none of the characteristics or traits that have been used in this classification appear in themselves as abnormal manifestations or as isolated traits. Probably every one is defective, emotionally unstable, and egocentric in varying combinations. No attempt, therefore, was made to apply a twelve-inch rule of analysis to human personality in general. It is important to note that this classification was confined to an analysis of the difficulties that the individuals concerned had experienced in their environment, including not only their military experience, but, so far as was obtainable, their whole record; that no attempt was made to determine whether an individual was emotionally unstable, egocentric, or defective in general, but only to explain as far as possible the difficulties experienced by him in the course of his life on the basis of one of these general characteristics or reaction types. As a result, one might set up a perfect scale in each classification of cases, with extreme manifestations at the lower end graduating at the upper end into cases that are hardly distinguishable from successful and eminently satisfactory individuals.

Each individual human being has his threshold value, his breaking point at which the balance between him and his social environment may be upset. When it is upset, however, the inherent personality will manifest itself and the reaction will be more or less consistent with his make-up. It is not for us to say in every case whether the individual was justified in his reaction or not. In many cases time alone will tell whether the egocentric trait, for instance, which manifested itself in an uncompromising adherence to the course of conduct once determined upon was desirable or not. Many a feebleminded person, many an eccentric, psychopathic individual, even in some cases an insane person, has contributed to the world's welfare; nor does the element of personal sacrifice or suffering form any decisive guide in this respect.

We cannot undertake to deal with this phase of the problem. For those of us who are approaching this subject from the point of view of the psychopathologist it is sufficient to give an explanation and not to attempt an evaluation. With the advantages that the army has had in the elimination of the unfit physically and mentally, such as is never possible in civil practice, it must be apparent that one of the principal problems of the correctional and penal field, if not of sociology as a whole, is the problem of what we have here termed the egocentric personality which so frequently manifests itself as the insubordinate personality.

It is not necessary in the face of these statements, however, to be fatalistic or pessimistic about this subject, for even though we may not at present be able to influence to any great extent the underlying personality and mental make-up of those who are placed under our care as a result of social difficulties, a great deal can be accomplished in producing an adjustment between the individual—whatever his peculiarities and however fixed these peculiarities may be—and his social environment. Even under the difficult conditions at the Disciplinary Barracks, it was easy to demonstrate that by a wise analysis of the difficulties, both on the personality side and on the environmental side, and by a recognition of the intellectual abilities and disabilities of each individual, such an adjustment could be effected; and that it was perfectly possible to maintain order and secure coöperation on the part of the prisoners, no matter which personality group or which classification of delinquency or behavior they belonged to.

That seems to me to be the contribution of the disciplinary service of the army to all welfare work. It may be summed up in this statement: the solution of the behavior problems of the individual depends upon as accurate as possible a knowledge both of the individual and of his environment; this knowledge can be obtained by the mental studies of the neuropsychiatric officer and the social investigations of the social worker, and their findings may be combined into a constructive therapeutic program which will ultimately, and often rapidly, reinstate the individual in the community as a safe and self-supporting citizen. While this program is more difficult in the case of the low-grade defective, even there it is more hopeful than is generally believed and is economically advantageous in all but perhaps the most extreme cases of feeblemindedness and insanity.

DISCIPLINARY PROBLEMS OF THE NAVY*

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THE problem of discipline in any military service is always one worthy of the deepest thought and consideration, and one which is far from being solved to the satisfaction of all its students. Some authorities approach the matter with only one object in view, the production of the maximum deterrent effect upon the mass; while others think upon the problem in terms of effect upon the individual in order to prevent a repetition of the same offense in that individual. There are officers in the navy who favor the maximum amount of punishment for every offense with the idea in mind of preventing the offense in others, and without consideration for the individual at court.

They believe that, generally speaking, the heavier the sentence, the less the likelihood of that offense being committed by other men. This policy is probably the easiest of application because it requires no large amount of deliberation as to sentence if the accused is found guilty, as he is given the maximum sentence allowed by law.

Other officers believe that each case is worthy of study from all angles before a sentence is imposed, in order that justice to the individual may be done. This policy is one usually well tempered with mercy; as a result each case requires more time and effort than when the first policy is followed. For the most part, the officers who believe in the second policy are actuated largely by humanitarian motives and they believe that the military does not suffer from the mixture of the humanitarian.

In the navy during the pre-war period, the problem of discipline was of relatively small magnitude, because of the relatively small size of the navy. But when the United States entered the war, the navy jumped in numbers of men tenfold, almost overnight. With this great increase in the enlisted personnel there was to be expected a like increase in the navy's prison population. On April 1, 1917, there were 268 general court-martial prisoners under sentence at Portsmouth. This number increased, by leaps and bounds, until August 1918, when the high water mark of 2,517 was reached. The monthly admissions were highest in February 1918, when 376 new men were admitted to the Naval Prison. The prison was built to accommodate between 300 and 350 men, so that temporary buildings had to be constructed to care for the rapidly increased admission, but it was months before these new buildings could take adequate care of the housing situation. A policy of restoration to duty of large numbers of men serving sentences for the so-called military offenses, after a portion of their time had been served, was instituted with the result that much relief was obtained by that means.

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*Read before the Mental Hygiene Section, National Conference of Social Work, Atlantic City, June 7, 1919.

Some idea of the types of men who constitute the population of the Naval Prison may be conveyed by saying that, of 1,895 admissions, 45 per cent are not over 21 years old, 76 per cent are not over 25, and 92 per cent are not over 30 years of age. Sixty per cent of them said they had reached the eighth grade in school; and 5 per cent of them had completed high school. From an occupational standpoint, at least 75 per cent of them belong to the class of unskilled labor. About 25 per cent of these 1,895 admissions acknowledge a court record prior to enlistment. Of the cases studied more intensively we have found about 50 per cent have resided at some previous time in a penal or insane institution.

A word should be said about the character of offenses for which men are committed to the Naval Prison. The list ranges from murder to drunkenness, and the sentences vary in length from life to three months. The majority of admissions are for desertion, absence over-leave, and absence without-leave. It is very difficult to say accurately just what percentage of the men are serving sentences for purely military offenses, but it is probable that about two-thirds of the offenses are of a military rather than moral character. However, the offense is of very little significance, except in a small proportion of the cases, in determining the diagnosis or prognosis in any given case, so far as social usefulness is concerned. In fact, the offense is often a very misleading bit of information upon which to judge a given case. I have in mind one man who came to the Naval Prison guilty of absence over-leave a few days who had, only a day prior to his enlistment, been discharged from a state prison where he had served a sentence for rape.

Organized psychiatric examinations of general court-martial prisoners were begun about November 1, 1917. Before that time interest in the psychiatric problems of general court-martial prisoners of the navy was only scattered and little organized effort was made to study the problem. In 1914 Passed Assistant Surgeon G. E. Thomas, U. S. Navy, at that time medical officer of the prison, undertook psychologic examinations of the men as they were admitted to the prison, together with the physical examination upon admissions, but I am told that he was able to accomplish little in the way of altering the course of any given case of mental abnormality, so far as a man's sentence was concerned.

When I was detailed to psychiatric work in the Naval Prison the lack of trained help and the lack of a place to work, because of the tremendous overcrowding, were very serious difficulties. It was not deemed advisable then to undertake a more or less superficial survey of the whole mass of prisoners because there appeared to be so many cases which had already attracted the attention of the prison authorities to their mental condition. An untrained yeoman was assigned to help me and we started by making complete examinations of cases referred by the officials of the prison. A full history of each patient was taken and where possible statements as to previous residence in penal or insane institutions were corroborated by correspondence. Each patient was examined psychologically and neurologically, and in some cases a period of observation was used in the Naval Hospital before arriving at our conclusions.

We began to find that about two-thirds of those examined showed evidence of disorder or defect at the central nervous system level. Then the problem of what to do with these cases arose; as a result in February 1918 a series of recommendations were made to the Navy Department, chief amongst which was the request for the construction of a psychopathic ward in connection with the Naval Hospital for the observation and study of cases. This request was approved with the result that now there is a psychopathic pavilion of two buildings completely equipped for the accommodation of 50 patients as a separate ward of the Naval Hospital. This ward may serve the enlisted men who are not prisoners as well as the general court-martial prisoners. There are now assigned to the work two medical officers, three yeomen, who have become fairly proficient in the taking of histories and giving the intelligence measure, two state hospital trained nurses, and eight hospital corpsmen, who are especially trained in handling psychopathic patients.

Since August 1917, the Naval Prison has been under the command of Lieutenant-Commander Thomas Mott Osborne, who introduced the Mutual Welfare League there for the self-government of the prisoners. Hence the conditions of living for the prisoners have been less exacting than under a strictly military régime, and there is less need for repression amongst the prisoners than in a strictly military environment. Free expression of individual characteristics, both good and bad, is possible. This factor, I believe, makes the psychological study not only less difficult but permits of reaching more accurate conclusions than is possible under what we commonly think of as the prison environment. Whenever a case is studied, a report of the diagnosis and recommendations, if any, is made to the Commanding Officer. These reports are intended for his guidance in dealing with that particular case. A report is also made in the man's Health Record, which is his medical department record in the service and follows him from his enlistment until his discharge from the navy.

A short interview is held with every man when he is admitted to the prison, and again when he is discharged from the prison. Upon admission, data are obtained concerning his age, civil condition, offense, length of time in the navy, arrests, diseases, habits, education, occupations, and any complaints he has to offer; he is then graded, arbitrarily, on a scale of four, as to his fitness for the navy. Upon release from the prison a note is made as to his conduct record while in the prison, his statement as to the benefit he has received in the prison, any complaints he has to offer and his intensions as to his future. These data are meager and only serve as a starting point from which cases are selected for complete examination.

During the period of nearly two years that this work has been carried on, we have made complete examinations of about 800 prisoners, and we have interviewed about 2,000. We have discharged from the service, by recommendation of a Board of Medical Survey for nervous or mental disorders, 108 general court-martial prisoners, and have transferred by the same means to St. Elizabeths Hospital Washington, D. C., 26 cases. There is, quite naturally, some reluctance on the part of the naval authorities in discharging certain prisoners before the expiration of their sentences because of mental abnormality, and there is always longer delay in obtaining authority for the discharge of a prisoner for medical reasons, than in the case of enlisted men who are not prisoners. However, an order from the Secretary of the Navy, in June 1918, directed that all prisoners, not physically or mentally fit for the service, be brought before a Board of Medical Survey for recommendation.

There has been a lack of uniformity in the psychiatric work at the various Naval Training Stations, but I believe that at most of the stations the psychiatrist has eliminated from the service army offenders, who otherwise would have gone on to the prison through the regular channels. Unfortunately, not all have been diverted away from the prison, who might better have gone elsewhere. Aboard ship where trained help is not available it is usual for an offender to be disposed of by a sentence rather than through medical channels.

In the navy when a man is convicted by a general court-martial, he is "read off" as the blue jacket says. That means that his finding and sentence are read aloud, in his presence, before the whole of the ship's company. This, undoubtedly, has a very definite deterrent effect, but just how much, no one, I believe, is able to say. It is not the successful preventative that we might wish. During the war, especially the first months of the war, the sentences administered were longer, for the same offenses, than had been given in peace time, and general courts-martial were given for offenses previously punished in other ways. So far as we were able to observe in the prison the increased sentences added very little to the deterrent effect, if any at all, and certainly not in proportion to the increase in the length of sentences.

The psychiatric approach paves the way, in my opinion, to a less expensive method of handling the problem of military delinquency. If the navy is regarded as a large organization, with a definite function to accomplish, then it behooves us to conserve the usefulness of the members of the organization as far as possible, for the benefit of the navy, and eliminate those who are a constant expense. From the cases we have studied we find that about 50 per cent of them are men of whom it was easily demonstrable that they were either nervously or mentally not fit for the service, and as two-thirds of our cases are men who find themselves in the Naval Prison less than one year from the date of their enlistment, it is reasonable to suppose that these men were also unfit when they enlisted. Therefore, the best single point of attack to the navy's prison problem is at the recruiting office, and it falls upon the shoulders of the medical officer.

Unfortunately, our state of knowledge is not so perfect that we can eliminate delinquents at the recruiting station by means of a yard stick or other instrument of precision, but the taking of a short social and medical history at the recruiting station will eliminate most of the undesirable types. I hope to see more responsibility put upon the recruiting medical officer in this regard. This may be done by keeping him informed as to the disposition of his recruits, and by rating the efficiency of a recruiting officer by the number of useful men he enlists, rather than by the number of men of all sorts.

It is gratifying to see the active interest displayed by the medical corps in the possibilities of prevention of military delinquency, and I am sure that the results of this interest, which we are beginning to see, will serve to deepen it.

THE FUNCTION OF THE SOCIAL WORKER IN RELATION TO THE STATE HOSPITAL PHYSICIAN*

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IT is probably quite unnecessary to emphasize so strongly as I propose to do the need for close coöperation and careful delimitation of function between social worker and physician but this relationship is of such fundamental importance that I offer no apology for doing so. Social workers, in my experience, are usually anxious to consult, and are fully conscious of the difficulties they experience when the physician fails to take his proper place, a failure which is on his part largely due to diffidence resulting from lack of training. But I think we will all agree that it is just as much an error for the social worker to take charge of a case and call in the physician only when she meets with difficulties as it would be for the nurse in a hospital. It is the function of the physician to make the diagnosis and to prescribe the treatment to be followed, leaving to the technician, be she nurse or social worker, the technique of its execution.

At the last meeting of the National Conference of Social Work I presented a specific plan for the organization of a state hospital for the treatment of the patient while within its walls. This present article must be considered as a corollary to that plan, which endeavored to emphasize in a practical way the preparation of the patient for return to social life.

In discussing the relations between the social worker and the state hospital physician it is necessary to consider the duties of, and the problems which confront, the latter. These have, in recent years, undergone large expansion which is partly expressed by the growing recognition of the need for the employment of social workers.

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*Read as part of a symposium on Psychiatric Social Work before the Mental Hygiene section of the National Conference of Social Work, Atlantic City, June 1-8, 1919. Other papers in this symposium, by Dr. George Kline, Miss Margherita Ryther, and Miss V. May Macdonald, are published in this issue. For papers by Dr. C. Macfie Campbell, Dr. Bernard Glueck, Dr. Edith R. Spaulding, Dr. E. E. Southard, Dr. Jessie Taft, Prof. William H. Burnham, cf. MENTAL HYGIENE, July, 1919; Miss Mary C. Jarrett, MENTAL HYGIENE, April, 1919.

Physicians in general are beginning to realize that their duties are far broader than the mere treatment of disease and that they must include the treatment of the patient as a man. This implies a study of him not merely as an individual composed of a number of organs each of which is liable to structural disease or damage but still more as a unit of a social organization in which he must so behave as not to menace his relation with, and the welfare of, the group of which he is a member.

While this statement is generally true for all medical work, it is quite specially true for that large group of disabilities which fall under the head of mental disorders. For while the welfare of the individual depends primarily upon the health and proper functioning of the organs which compose his body, his successful adjustment to social life and the welfare of the social group itself depend upon his behavior, which is the use he makes of the bodily organs with which he is provided. Social behavior is nothing but the proper regulation of body activities and is rendered possible by the activity of the brain, which is the mind.

Disorders of the mind are thus essentially disorders in behavior and of necessity imply greater or less social discord. Even serious bodily handicaps do not necessarily preclude a social adaptation, but mental disorder means that the individual is more or less extra-social and sometimes actively antisocial. The science of mental disorders, or psychiatry, deals therefore essentially with social problems and conversely one is justified in stating that there is a psychiatric element in all social work. Dependency, delinquency and insanity may, it is true, be the result of bodily disease or defect and be therefore medical in the more narrow interpretation of that term but in so far as these conditions are social problems they are psychiatric and the physician is concerned not only with the problem of restoring the individual to health but also with establishing a type of behavior compatible with the handicaps present and the requirements of social existence. The recognition of this psychiatric or mental element in social work is, I believe, of fundamental importance if we are to avoid in this field the errors of omission which have so long lowered the efficiency of medical practice.

The state hospital physician is primarily a psychiatrist, his special field being that particular group of mental disorders classed under the heading of insanity. The sole reason for the admission of patients to state hospitals is the disorder of conduct which renders them incapable of social existence. A paretic, for instance, is not sent to a state hospital because he has syphilis of the brain but because his conduct either already has been, or is liable to become, such as to render him a menace to himself or others. It is therefore somewhat astonishing to find that it is only now that we are beginning to appreciate the importance of employing social workers in connection with state hospitals. Like the general hospital, the state hospital has concerned itself with the treatment of the patient merely as an individual suffering from some "disease" obscure though this most often is admitted to be.

Many persons are even yet unwilling to recognize that insanity at times may not be associated with disease at all but be merely a mode of reaction to the conditions under which the particular individual, with whatever handicaps as to structure he may have, finds himself, and thus be a social problem almost purely, the remedies for which must lie in the modification of the conditions to be faced and the training of the individual to better methods of meeting them.

The majority of state hospitals even today are concerned only with the care of the person insane and content themselves in their anamnestic study of the patient with a history of the bodily diseases and defects which have preceded the onset of the insanity. Should no disease capable of remedy be discovered the treatment is liable to become purely custodial. Under the simplified conditions of life which obtain in the hospital the patient often improves very materially and may sooner or later be considered fit for release. He is liable then to be permitted to return to conditions more or less the same as those under which he broke down before. Often, it is true, he has suffered a definite lowering of mental capability which, while it may possibly render the danger of actively unsocial conduct less, must nevertheless render the probability of dependency far greater. Such persons are much in the position of the old-time handicapped soldier. His wounds had healed under surgical treatment but he had lost a limb or become otherwise crippled and only too often he remained more or less helpless and dependent upon charity or descended to peddling shoe-strings for a living.

To guard against a repetition of this state of affairs our present government has wisely decided to establish machinery, necessarily somewhat elaborate, which provides not only for the best possible medical and surgical treatment of the damaged parts of the body, designed to restore them to the greatest possible degree of usefulness (this corresponding with the view most usually adopted of the function of the state hospital) but which will in addition aid the study of possibilities in the way of useful employment and placing of handicapped men and the training of these men for work which they can adequately perform and in which they can successfully compete with their more fortunate fellows.

The problems before the state hospitals are essentially the same, varying only because of the kind of disability. This difference, however, renders the study of the patient alone often quite insufficient for the definition of the causes, and hence the proper treatment, of the breakdown from which the patient is suffering. These are often extremely complex and may be compounded of disease and its consequences or defect of the patient's body *ab initio* with difficulties of social adjustment. Of these latter the patient can often tell little or nothing and it becomes necessary to discover the facts by a study of the environment in which the disorder developed. This environment includes not only the patient's home and relatives but also the conditions and associates of his work and play.

The investigation of these conditions is an important function of the state hospital social worker. To carry them out requires some knowledge of the symptoms of mental disorders and their relation to social adjustment, in other words a psychiatric training. While much of the information to be collected may be more or less routine, it is essential that it be selected in the light of the needs of the individual case. For this reason there must be close coöperation and consultation between the physician and the social worker, for it is only the former who, by reason of his psychiatric knowledge and study of the patient, can specify the needs.

In the course of the studies of the patient himself by the physician and of the environment from which he comes by the social worker, it may well happen that conditions are discovered which have a direct influence upon the immediate happiness or distress of the patient, such as the dependency of his family upon relief, etc., or which may be of importance to society for the prevention of later difficulties such as syphilis or of some other condition which might lead to the breakdown of other members of the family. These it will of course be the function of the social worker to deal with either directly or by reference to other special agencies devoted to such needs.

Upon the results of the study of the patient combined with the facts elicited by the social worker concerning conditions which have prevailed prior to the onset of, and which perhaps have precipitated or even caused, the disorder in behavior which was the occasion for commitment of the patient, must be based the prescription of treatment. It cannot be too strongly emphasized that this must be purposefully designed to fit this particular patient for the resumption of social life under conditions which offer a probability of success, and I believe that much is to be gained by laying down, quite early in the period of the patient's residence at the hospital, the specific conditions which must be fulfilled before release can be considered.

Part of these conditions quite frequently concerns the outside environment of the patient fully as much as it does the patient himself. Treatment applied to the social surroundings such as readjustment of home, work and play conditions, the settlement of family and neighborhood conflicts, prejudices or misunderstandings, the education of relatives and others as to their attitude towards the patient, etc., may be as important factors in determining the return of the patient to a social existence as the training of the patient himself. Such treatment should not be left until it is time for the patient to leave but should be initiated at the earliest possible moment after he enters the hospital.

The execution of this program is quite obviously work for the trained social worker, requiring a high degree of tact and skill combined with a knowledge of the possibilities afforded by communities in various localities. Here again it is evident that the very closest coöperation between physician and social worker is essential in order that unnecessary meddling and unwise changes may be avoided. The function of the physician is to make a diagnosis by giving due weight to all available facts and upon this basis to prescribe the remedies. The task of finding the way to accomplish the ends prescribed in so far as they concern the relation of the patient to the social world is the function of the social worker. Obviously these results can be materially favored by requiring the social worker to be present at staff meetings where the treatment of the patient is discussed.* To gain anything of value from such discussions she must be familiar with psychiatric terms and the significance of behavior types.

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* As a digressive corollary I might add that it would be well to have the responsible nurse and other therapists who will have charge of the treatment of the patient himself while in the hospital also present at these discussions so that all may work together more intelligently. The social worker, it is true, must of necessity work less under the direct supervision of the physician than the nurse and it is hence imperative that she be fully cognizant of the results desired and the reasons for their prescription.

Thus far we have considered only the functions of the state hospital as they have largely been limited in the past. Its duties did not begin until the disorder was so fully developed that commitment was necessary and too often it ceased to concern itself with the patient after he left the hospital. Today it is realized that the state is to a great degree vitally concerned with the prevention of the need for commitment and with the after-care of patients when released. Since this means the study and treatment of persons living in society it is obvious that this field is especially one in which the social worker is a prime essential.

To be successful in any degree this work must be given the same careful consideration as to diagnosis and treatment as that given to the patient at the time of commitment, and hence again there must be the same close relation between social worker and physician. Let us consider first the question of after-care, which is so obviously a part of the function of the state hospital that it is difficult to understand why it has been so much neglected.

If the plan already outlined as part of the treatment of the patient be followed, (i. e., modifying unfavorable conditions in the environment as early as possible after commitment, combined with purposeful training of the patient himself in habits of occupation and recreation within the hospital, with his limitations, handicaps and the surroundings to which he is to be released kept in mind) there is established a definite criterion as to the conditions for release and this becomes part of a carefully planned line of treatment.

But, however carefully approached, this release must of necessity represent a more or less abrupt transition which needs the most careful supervision if it is not to result in failure. It is necessary that the social worker who is to maintain this supervision be thoroughly familiar with the patient, his difficulties and disabilities, with the general plan of therapy which has been, and is to be, followed, and also with the environment into which the patient is going; she must be furnished information concerning the possibilities as regards special dangers to be avoided and difficulties to be met which can be given only by the physician. Provision must be made for reports at suitable intervals as to progress, for consultations upon desirable modifications or changes in the treatment prescribed and for interviews between patient and physician as occasion, foreseen or unforeseen, arises.

All these considerations must be made the subject of definite prescription which should be given by the physician in writing. The reports of the social worker as to methods employed and results achieved must also be written. Only so can we ever secure data upon which can be founded a better and more rational treatment of mental disorders of this type.

If such a system is adopted and honestly followed there is plenty of evidence to show that many persons now considered as doomed to life-long residence in a hospital can be restored to productive activity in a more or less restricted social environment.

During the war, when labor was scarce, we made the experiment in one of the Illinois hospitals of permitting a number of patients from the custodial, or as I would prefer to group them industrial, wards, to work in a neighboring factory where the management offered intelligent and sympathetic coöperation. The patients continued to reside in the hospital but worked in various departments of the factory at a full wage. The working conditions and the patients themselves were under the supervision of a social worker. The experiment was eminently successful and was entirely satisfactory to the employer, who asserted that he had never had more efficient help.

Unfortunately, with the signing of the armistice and the release of many workers from war activities, the labor unions objected, with some justice, that the competition was unfair, as the patients were still inmates of the hospital and received maintenance from the state. As a consequence, those who could not be released altogether had to be withdrawn. A practical solution of this difficulty may possibly be found by establishing, under the supervision of social workers, community houses in which such patients may live and be entirely self-supporting. It will require, however, the intelligent coöperation of both employers and labor organizations.

Finally we may consider briefly the function of the social worker in relation to the state hospital physician in connection with the problems of prevention. The interest of the social worker in this field is self-evident. That it equally belongs to the state hospital needs but little argument. The exact relationship between hospitals and preventive work is largely a question of organization, but the physicians of these hospitals are practically alone in having an opportunity for psychiatric training.

In some manner, which may be varied to suit local conditions, it is necessary to provide clinics outside the parent hospital as close to the community as possible. These will be of value also in providing for after-care. To these clinics can be brought for examination and advice any persons who show indications of the danger of a failure to meet requirements. It will be the function of the social worker to establish communications between these clinics and the communities and to supervise and manage such treatment as is recommended. The relation of the social worker to the community is to be discussed in another paper and hence will not be considered here.

It is however essential to realize that successful prevention depends upon the anticipation of actual breakdown and that the social worker must be prepared to assist in giving instruction to the community as to the importance of such manifestations and the need for expert advice. The possibilities from these activities have been well demonstrated by the psychiatric work of the army physicians who established communications with prospective patients through line officers and non-commissioned officers who thus served in the capacity of social workers.

In concluding it may be pointed out further that the field of social service outlined here for the state hospitals exists equally in other forms of mental disorder or social maladjustment, including dependency, delinquency and crime. Just as with insanity, though disease and defect may enter into their causation, the real reason for social interference is conduct disorder, and hence they belong in the province of the psychiatrist for diagnosis and treatment just as does insanity. The problems to be met, though different in detail, are still essentially the same, and the functions of the social worker, as an aid to diagnosis, social rehabilitation, prevention and after-care, are identical.

SUMMARY

The social worker is a technician trained in the means for social adjustment and their application who, in relation to the state hospital physician, will have the following general functions:

1. To collect information of social conditions which existed prior to commitment and thus permit the establishment of rational diagnosis and treatment;

2. To apply to the social environment such measures as will be calculated to relieve worry and apprehension on the part of the patient, to prevent further breakdowns in the family and to prepare the way for the release of the patient;
3. To supervise the rehabilitation of the patient in society by assisting him in his relations with others, finding suitable occupation and recreation, and affording means of communication between physician and patient;
4. To establish relations between the state hospital physician and those who are in need of assistance by reason of habits of behavior which threaten danger of disharmony with society;
5. To carry out the treatment prescribed by the physician with a view to prevention of actual breakdown and commitment.

THE FUNCTION OF THE SOCIAL WORKER IN RELATION TO A STATE PROGRAM*

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DURING the last few years, state institutions have been increasingly broadening the scope of their activities and endeavoring to serve the community as well as improving methods of care and treatment within the institution. To this end the establishment of social service departments in the institutions caring for the mentally sick has played a very important rôle, it being recognized that social factors have a very definite bearing upon mental diseases,—their causes, treatment and prevention.

Before analyzing the relationship of social work to a state program, it may be interesting to note the development of methods used since early days and the laws and customs pertaining to the care of the insane in the United States. One may thereby gain a deeper insight into the functioning of social service in connection with a state policy as regards care of mental patients.

The right to deprive an insane person of his liberty existed in England under the Common Law which was transferred to the colonies of America. It was regarded as justifiable to "confine, bind and beat in such manner as might be required under existing circumstances." Care by relatives consisted mainly in confining in cells, pens and cages in most unhealthy conditions. The policy was that of economy.

In colonial times there was no machinery to enable the state to carry out its obligations to the dependent classes; therefore very few references are made to the dependent insane. In New England the care of the insane devolved upon townships or city councils and came to notice only when they needed charitable assistance. The dependent insane were classed as paupers—the first known settlement law was in 1639. The earliest legislation in Massachusetts was in 1676 which delegated the care of the insane to the selectmen and overseers of the poor. In 1736 this power was transferred to the judges whose action was largely based upon the opinions of the overseers and selectmen. A law was passed in 1715 requiring near relatives to provide for insane members of their families; if they neglected to do so, a fine of 20 shillings was imposed upon them—the money being used for the dependent insane. Amendments to this law soon followed which were directed to the protection of the patients' property rather than to his personal comfort and safety.

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In 1727 "disorderly persons" had become so numerous that a colony workhouse was built to which *all* disturbers of the public peace were committed regardless of their mental condition. A little later another law was passed to confine such "disorderly persons" in county jails—but in 1797 this section of the law was revoked. So far as known between the years 1793 and 1824, there was no public place in which harmless insane persons, not criminal, could be confined. In 1824 a law was passed whereby any person could complain to one of the civil authorities if he found an insane person at large. If no action was taken in 3 days, a justice of the peace could confine such a person, providing that adequate proof of his insanity could be produced.

According to Mosher, the first statute in existence regarding the insane is an act passed in 1788 under the title, *An Act Apprehending and Punishing Disorderly Persons.* This Act provided:—"Whereas there are persons who, by lunacy or otherwise, are furiously mad and so disordered in their senses as to be dangerous to go abroad, it shall be lawful for two or more justices of the peace to cause to be apprehended and kept safely locked up, such persons in some secure place, and, if necessary, to be chained there if their legal settlement be in the city or town of that county."

Some of the earlier records describe very closely the terrible conditions under which the imprisoned insane existed. The cells were literally dark dungeons—planks and straw were used as beds—inmates were clothed in filthy rags and were hardly recognizable as human beings. Air and light, if any, were admitted by means of 2½ foot window-openings into the prison. Frequently these persons were found in cellars whose windows were so in disrepair that snow and rain often fell upon the inmates and "there were times when it was difficult to keep them from freezing." Heat and cold were never tempered in these cells. It was not until 1827 that an Act was passed providing that—"A lunatic shall not be confined in any prison, jail or House of Correction in the same room with a person charged with a criminal offense."

Prior to the 19th century, care of the insane in America was largely a local matter and was entirely custodial. There are no records in England, Europe or America to the contrary. The purpose of confinement was for safe keeping and was accomplished in ill-ventilated and inconvenient cells or pens in the basements of hospitals and other places. This was the only care that the medical profession and the public deemed necessary for this most wretched class of human beings. It is a well known fact that in many states, notably in New England, the contract for the pauper insane was awarded annually to the lowest bidder—not due to the fact that they were less considered than other dependents—it was the custom thus to make provision for dependents. In Connecticut, Massachusetts and New Hampshire, the insane poor, being classed as paupers, were annually sold at auction to those who were willing to care for undesirable persons for a money consideration. If families were not available or the person was dangerous or untidy, he was placed in a jail or strong pen in the care of relatives.

It is interesting to note that such treatment and the resulting conditions naturally appealed to philanthropic and benevolent people and many private donations were made for better care in private hospitals. The Pennsylvania Hospital Department for the Insane thus developed into the present institution; the insane department of the New York Hospital thus became the present Bloomingdale Hospital; the McLean Hospital of Boston performed a similar service until the establishment of the Worcester State Hospital.

In passing it is well to note that county care of the insane originated only as an emergency, when no suitable provision could be found elsewhere and county jails were simply an emergency provision. Nearly every state has a history of county care. The necessity of providing for chronic cases led several large cities—Boston, New York, Chicago and Philadelphia—to build Municipal Hospitals. These institutions were managed by local men, inexperienced and untrained, whose chief concern was economy rather than humanity. Lack of standards, abuses of various kinds and lack of uniformity are the outstanding features in county and municipal care of the insane and without doubt hastened the movement for state care.

The first pauper insane state hospital was established at Worcester, Mass., and opened in 1832. The next was in New York, 1843. In Massachusetts, three classes were eligible to admission: First, those persons who had been committed by Justices of the Supreme Judicial Court or Justices of the Peace, to jails; second, town pauper-lunatics who were confined in poorhouses and those persons who had been contracted out to jail keepers and House of Correction officials. The third class included all those insane not mentioned in the other two classes.

The development of the state hospital was slow and materialized after severe struggle. When humanitarian sentiment became fully aroused, its expression was noted in the erection of well organized buildings, pleasant situations and modern methods of heating and ventilation, but no pains were taken to study the personal comfort of patients. Airing courts, surrounded by high walls, did not add to the welfare of patients. A sort of *laissez-faire* policy existed in the hospital; patients who destroyed their clothing went without; those who destroyed bedding or refused to lie in bed, slept on the floor, etc. Until 1880 mechanical restraint methods were extensively used and were believed to be absolutely essential in caring for the insane. The theory of treatment was to "overcome patients through fear, to break their wills" and to teach them that stronger wills than theirs were in authority. Gradually non-restraint methods were introduced, first in Canada, then in Michigan—soon followed by New York, Massachusetts, and other states. For a long time these non-restraint methods were sporadic and not entirely successful as no outlets for the energies of patients had been provided; with the introduction of industries, recreation, amusements, etc., these methods became successful and within the last 25 years have made their way throughout the United States. In Massachusetts, the state policy of mechanical restraint (with rare exceptions) is forbidden by law.

It is fair to presume that the present methods of caring for the insane would have been long delayed but for the marvellous work of Dorothea Dix, whose strenuous battles for the welfare of the insane resulted in reforms commencing in Massachusetts and spreading throughout the country and in some parts of Europe and England. In Massachusetts her efforts led directly to the enlargement of the Worcester State Hospital.

State care, which developed naturally, is the care by the state of the dependent insane as state charges and is in no way under the supervision or management of county or town officials. The advantages gained are the welfare and well-being of patients and are the first consideration. As far back as 1811, Doctor Wyman, first superintendent of the McLean Hospital, advocated the "judicious moral treatment of insane patients" in which he recommended employment, such as sewing, garden work and recreation as valuable for the minds and bodies of patients. He believed in and advanced the idea that "the law of kindness was the all-pervading power of moral discipline." But he was a man far in advance of his time and his theories met with considerable opposition. Those who visited state hospitals a generation or two ago found large numbers of patients whose condition was deplorable; they were noisy, destructive, untidy, incapable of employment because of more or less constant restraint and seclusion.

The state hospital of today, which is a far reach from the county jail and asylum of yesterday, is both custodial and educational. The policy of early days was economy in caring for dependents: the policy of today is based on humanitarian principles; then it was safety for the public, now it is the restoration of the patient.

In reading the history relative to the care of the insane, one is impressed with the fact that conduct disorder has ever been the cause of confinement. The early methods of treating such disorders, beating, binding and otherwise cruelly treating them, stand out in marked contrast to modern methods of caring for mental patients. Recognizing the fact that such patients are frequently free from bodily disease, so far as can be determined, and that conduct disorder is the outstanding feature, the keynote of treatment is education; hence the various forms of industry, exercise, recreation and amusement which characterize the modern state hospital. Patients are now treated with a view to assisting them to adjust themselves to the existing social order. They are regarded as patients, not paupers. In place of economy, social welfare is the basis of treatment. The state policy of today in the care of the insane may be briefly defined as one in which all those factors which have a bearing upon mental health are carefully and scientifically considered. Reformed laws removing the insane from the care and custody of justices of the peace, overseers of the poor and jailers make it possible to give such persons medical care. The conditions surrounding them in state hospitals are arranged for the purpose of promoting physical and mental health. The development of occupational therapy, mechanical arts, recreative amusement, etc., has had a quieting and helpful effect upon patients; the policy of boarding special patients in private homes under good normal conditions; the establishment of psychopathic wards in general hospitals and psychopathic hospitals for the study of borderline and incipient cases and investigation of mental diseases, and the recent establishment of social service—are all indications of an enlightened policy in state care of the insane. Such care insures efficiency, standardization and uniformity and makes for progress.

All the contributing factors, medical and social, which have played a part in the breaking down of the mental faculties should be intelligently considered. It is interesting to note that the causes of mental illness as given by the laity are largely social causes:—poverty, hardship, worry, overwork, alcoholism, immorality, irregular habits, unfortunate love affairs, social maladjustments, etc. It is obvious that these factors cannot be lightly ignored for they must perforce play a part in future treatment. Doubtless the importance of social factors has long been known to the hospital physician, but heretofore there seems to have been no practical way of dealing with them until social service, having proven its worth in the general hospital, was gradually introduced into the state hospital. The purpose of this department is for the social welfare of patient and community and for effective hospital treatment. This department of state hospital organization is young and a great deal of elementary work has been obviously necessary. The functions of social service in the state hospital will be guided largely by the interpretation which hospital superintendents and governing bodies give of the work. At the present time the main functions of social service are to contribute to psychiatric knowledge and to aid in matters of social adjustment.

The value of social work to any state hospital depends largely upon the quality of the case-work. Social problems under which the patient broke down, employment, habits, moral and physical environment, are all significant from medical and social standpoints. The knowledge of these factors plus the medical findings will generally indicate a form of treatment and aid in matters of social adjustment. Teamwork is absolutely essential between physician and social worker if good results are to be obtained. The psychiatric social worker, at the present time, largely confines herself to the study of environmental conditions and their relation to mental states. When this work is more firmly established, doubtless the study of personality will be equally important and effective, especially when one considers that problems of personality constantly occur in matters of adjustment to home life, community conditions and industry.

Social history work is an important branch of this department and means that the best outside resources are used in obtaining knowledge which the physician may require in matters of diagnosis. Such work aids not only the physician but assists the hospital in acting intelligently and constructively when placing patients again in the community.

Next in importance to social case-work and history-taking is community work. To a large extent, social organizations in the community supply the machinery for the readjustment of patients. The problem of the psychiatric worker is largely to coördinate their special services for hospital use. The contact with these agencies must be made in a close, intimate manner in order to secure efficient results. The hospital must be in close touch with the schools, charitable agencies, recreation centers, employment agencies, hospitals and churches, through its social service department. Another branch of work which it is the privilege of the social worker to perform is to contribute knowledge regarding the social laws of mental health wherever the need for such may appear. An interesting part of the earlier duties of the state hospital social worker has been to impart correct information regarding hospital methods. Ignorance in regard to state care of the insane is by no means confined to individual cases. Fear of state institutions is being substituted, in a most encouraging degree, by coöperation wherever hospital methods are clearly understood by relatives and other interested persons. All possible encouragement is given to those in need of medical advice to use hospital resources. The interpretation of the hospital to the community and aid to individuals and social groups means that coöperation is being established and that hospital and community are joining forces for a common purpose.

Recent studies have shown the possibilities of preventing many forms of mental illness—so-called borderline cases between the normal and defective groups—especially those types of disease connected with fatigue, anxiety and social maladjustment. In many instances suitable and early knowledge would result in prevention of more serious conditions. The establishment of psychopathic hospitals may serve to open the way for much preventive work. The psychopathic hospital, established mainly for the study and investigation of mental diseases and for the care of early cases of mental illness, should have a well organized social service department in order that the social studies and investigations may contribute to medical knowledge. The out-patient clinic, which is the natural outgrowth of the modern state hospital, serves the double purpose of keeping in touch with former patients and acting as an educational center for needy individuals outside the hospital who desire information. The future development of these clinics, at which the social worker is usually present, will doubtless mean that they will be as commonly used as those of a general hospital.

Social service, from the viewpoints of education and legislation, covers a broad field. The community should know more of mental disorders, causes and prevention, and should be encouraged and urged to assume much the same attitude which it now holds toward tuberculosis and syphilis. The proper education of children, especially as regards early mental development and social habits, is vitally important. School, or even college education as such, does not necessarily fit one to meet the difficulties of everyday life. The combination of physicians, clergymen, teachers and social workers along lines of mental hygiene will help tremendously to form public opinion in the field of mental health. Statistics, compiled by such persons, must eventually lead to special legislation in the department of mental health.

The movement to make social service an adjunct to psychiatric treatment is apparently gaining in popular favor and will doubtless become a recognized part of the state hospital organization scheme. In Massachusetts, the Commission on Mental Diseases has recently adopted social service as part of its policy in caring for mental patients and holds a place on the state program. This work is being gradually introduced into the various hospitals connected with the Commission; out of 14 hospitals, 10 are now engaged in some form of social service. A most encouraging feature of a recent survey of these institutions was the practically unanimous desire expressed by superintendents for such work. This section of the states's program indicates that social service, both intra- and extra-mural, connected with the institutions under the Commission, is to be established on a firm basis. A comprehensive plan for coördinating and developing the various phases of the work includes uniform records and statistics, standardization of methods and correlation with the various community resources. Subdivisions of the work are:—development of case-work, social investigation, history work, placing and care of boarding patients, after care work, special studies, etc. A division of the work yet to be developed is that connected with the out-patient clinics. The demand for workers is greater than the supply and necessitates the establishment of a system for training students and volunteers. A tentative plan is in process of formation.

The future development of psychiatric social service in connection with state hospitals will depend largely upon the organization of the work and upon the qualifications, natural and acquired, of persons who enter the service. The social service department of a state hospital, although distinct in itself, should be so organized and developed that it will fit smoothly and harmoniously into other departments of institutional work and enable its machinery to run effectively. In every respect its purpose is to fit into the general policy which the state has adopted in caring for its mentally sick and defective. The spirit of social service should pervade the hospital atmosphere and serve as a constant reminder to those interested in patients and in the general care of the mentally disordered that social welfare is more valuable than economic and scientific methods—that human kindness is a more powerful agency than the exercise of temporary authority or the exhibition of power and in reality *is* "the all-pervading power of moral discipline."

THE FUNCTION OF THE PSYCHIATRIC SOCIAL WORKER IN RELATION TO THE COMMUNITY*

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THE activities of a social worker in a hospital for mental disease parallel the same work in a general hospital, though there is emphatic need of special training to deal with the mental problems involved. It is the social worker's privilege to assist in discovering the contributing causes of the patient's breakdown, and to render whatever service will promote his welfare while in the hospital and help to reëstablish him in normal life when he is allowed to leave. The function in the community of a social worker for the mentally disabled is less well understood; it is not so apparent where and how she will get into touch with those who need her services. Her protégés may not come to her listed and diagnosed as in a hospital, with an outline of future treatment sent by the physician. They may never have been in a hospital at all. In many cases, they will not *come* at all. She must go to them. It is evident that, besides the general means established to secure mentally wholesome education and environment for the community, there must be an intermediary who can deal with those who are beginning to evince mental abnormality. Some years ago Dr. August Hoch, in an article on *The Social Side of Psychiatry*, said, "If we wish to adopt measures for prevention upon thoroughly practical grounds, we must recognize that our field lies in measures which are primarily aimed at individual cases—measures which aim at getting at the cases much earlier than we do now." And again, "I am sure we could help such early cases if we could really treat them when such difficulties are seen to arise. Many could be saved if we could take them out of their environment, enter into their struggles, place them in an atmosphere where stimulation of healthy interests would be the uppermost aim."

Dr. E. Stanley Abbot says, "Probably from 16–20 per cent of the yearly admissions to hospitals for the insane are due to breakdowns in persons who were unable to withstand hard, continuous work, or the exhaustion of illness or pain, or the sudden and intense, or the long continued, stress of conflicts between opposing desires, ambitions, and duties, or the strain of prolonged responsibility." And again he says, "Perhaps a half, possibly more, of the manic-depressive psychoses might be prevented."

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Dr. Ferris, formerly President of the New York Commission in Lunacy, says, "The fourth important cause of insanity consists of fatigue, stress, and strain in specially susceptible individuals. Stress and strain are very often due to improper environment, including housing, clothing, occupation, recreation, food, and habits of thought." Surely here is indicated a sufficient and legitimate field of work for the psychiatric worker. To promote this preventive work, which is the most valuable in terms of conservation, she must be prepared not only to help those who feel their need, but also to search out the incipient case, the border-line neurotic, and the troublesome unrecognized high-grade defective, whose maladjustment to society is not understood. With the advice of a psychiatrist, she can proceed to readjust the personal, social, or industrial factors in each separate problem. A grounding in psychology, added to some training in psychiatry, and an acquaintance with the more frequent forms of nervous and mental disease do not turn a social worker into a psychiatrist or qualify her to deal single-handed with the mentally disabled; but this training makes her more keen to detect early symptoms and more anxious to secure the advice of a mental specialist. Under his guidance she can intelligently undertake the suggested restorative or protective treatment. The psychiatrist will welcome her assistance as cordially as will the family of the patient.

The presence in a city of a worker who knows something of mental diseases, and is known to stand ready to help with "worries," is often enough to bring to her problems that would never be referred to a charity organization or to public health advisers. Sufferers themselves may seek her advice, or their anxious families may come for help.

An intelligent girl of twenty-two, working as a telephone operator, found herself growing constantly more depressed and more painfully self-conscious. It was very difficult for her to adjust herself to ordinary conditions of work. She felt that she was different from other girls. Anxiety pressed upon her, and she began to fear that she would be unable to continue the work which helped support her mother and sisters in a distant city. A chance pamphlet brought her to the psychiatric worker for advice.

Her family history was highly suggestive of probable breakdown. The father, a worthless man who had been guilty of crooked dealing in financial matters, had left the family to support themselves. He was said to have been always very nervous and irritable. The mother was overanxious, depressed, and weak-willed. The five sisters and one brother showed various forms of mental lack of balance, such as passionate outbursts, exaggerated shyness, seclusiveness, irregularity at work. In a word, it was a family providing fruitful soil for the mental catastrophes of adolescence. This oldest girl was examined and advised at a mental clinic, and was then placed in the social worker's charge to carry out a program that regulated her recreation, her diet, her books, and her companions, and directed her thinking. In three months she had gained five pounds and had acquired a self-control that secured her normal enjoyment of wholesome pleasures. Her intelligent appreciation of what had been done for her induced her later to bring to the clinic other members of the family for advice. For one sister the best that could be done was to delay the development of dementia praecox for a few months, but a younger child was cured of passionate outbursts, and a young brother tided over a period of exaggerated sex consciousness.

Frequently the general practitioner realizes that a case of incipient mental disease demands constant, intimate advice and a supervision that he has neither the time nor the opportunity to give. Such was the case when a family physician referred to a psychiatric worker a young Jewish girl who, he feared, was definitely insane. Examination at a mental clinic resulted in a diagnosis of a border-line condition in urgent need of general supervision by a trained woman. The girl was sixteen and had been working since fourteen in a factory where she could not avoid hearing obscene stories related by some rough co-workers. These stories had made a lasting impression; they were intensely repugnant to her. The struggle to suppress these repulsive ideas had brought her to a state of collapse. She could not sleep, wept copiously and almost constantly, would not eat, had lost twenty pounds in weight, and wanted to die to end the conflict. The family were sympathetic, but helpless. A short vacation, a change of work, and above all several frank talks which placed certain facts on a healthy, normal basis, coupled with a general supervision of diet, recreation, and companionship, were sufficient to work a remarkable change. In a few months she was rosy, smiling, happy at work, and had regained her lost weight. The family regarded her changed condition as a miracle. There has been no recurrence of the trouble in three years.

Sometimes the one effective treatment will be urged by no one but a psychiatric worker. In a city well supplied with the usual philanthropic and advisory agencies, a woman came in deep anxiety to ask advice about her husband's condition. She was in constant dread of finding him a suicide. For a year he had brooded on self-destruction; his restlessness drove him into long walks until he was too exhausted to set out again; his indecision was a torment, his depression abysmal. Three general practitioners, in the course of a year's treatment, had given him sedatives and advised open-air exercise. This man had broken down four years previously, and by prolonged treatment at a mental hospital had been sufficiently restored to enable him to resume his work as engineer on a fast express train. In an interview with the man himself he acknowledged, after agonized protest, that he knew he would be better in a hospital where some one other than he himself would regulate his conduct. One day more of the exhausting conflict and he came to say that if the worker would herself take him to a state hospital, he would go at once. This was done, and after some months of treatment he was again restored and back on his engine. This was a frank case of manic-depressive insanity in which the patient should have been spared months of suffering and constant danger of suicide.

While the comfort and help given to actual sufferers is a sufficient reason for any effort that may be made by a community worker, the protection of other unaffected persons may give a double value to her work. Workers untrained in psychiatry, and philanthropic societies unused to dealing with the mentally diseased, are very likely to shirk responsibility in this difficult kind of problem. In this way dangerous conditions are often allowed to persist. An infant-welfare nurse reported that the mother of a three-weeks-old baby had been behaving and talking curiously for some months, and that the doctor said she was intemperate and perhaps insane. He had taken no steps in the matter whatever, though he had said he was sure the infant would die of mishandling or neglect, and the woman's condition was common knowledge in the neighborhood. The psychiatric worker secured an immediate mental examination of the woman which revealed an alcoholic psychosis with ideas of persecution and a tendency to impulsive acts, rendering her a most unsafe guardian for the child. The woman's sister was brought from another city, the legal preliminaries were hastened, and within a day the mother was in the state hospital and the baby suitably cared for elsewhere.

A similar case was that of a Jewish woman, haggard and worn, who came to say she could no longer endure the terror she had suffered for two years from the frequent threats of violence made by her husband, who was growing increasingly irritable. He had given up work, and on her had devolved the task of supporting six children and protecting them from his violence. His examination at a mental clinic showed well-advanced general paresis and need for immediate action. Within two days the man was committed and the family relieved from an intolerable strain.

A well-known physician telephoned asking a psychiatric worker to give necessary advice and help to the family of a woman he had seen and treated only a week before. The woman, sixty years old, had been worried for a year by fears of misfortune, and had finally almost succeeded in an attempt at suicide. After a few days of semistupor, she had raved of persecution and had had hallucinations of sight and hearing. The doctor had sent her to the country to a sister with no warning of her dangerous condition, and it was not surprising that very soon she crept up behind the sister and struck her on the head with an axe. The blow was fortunately not fatal, and the sister tried for some days, until exhausted, to guard the insane woman. Then it was that the psychiatric worker was notified. She was soon able to persuade the family that immediate commitment was the only course, and to help with the necessary procedure. Within a day further danger was averted by having the woman placed in the state hospital.

The protection needed by the community is sometimes moral rather than physical. Since feeblemindedness actually means an adult body governed by only a childish intelligence, there will always be a moral problem while these defectives are at large.

A feebleminded girl of fourteen, with a mental age of four, already a pupil in a class for defectives, was developing into a moral plague spot, contaminating the other pupils and the children in the public playground. Her father was alcoholic and her mother densely ignorant and suspicious of any institutions. No one seemed to be able or willing to deal firmly with the problem. It required many visits to the family, to their priest, to the city authorities, to the city courts, and to the school board, before the psychiatric worker succeeded in placing the child in an institution for the feebleminded.

Instances of pronounced disease which require institutional care both for their own and for the community's sake are often cases that might have been prevented had the earliest symptoms been recognized. The most valuable psychiatric work that can be done in a community is obviously that which prevents the development of serious conditions. The present problem of reëstablishing in civil life the discharged soldier is proving to have in it a large psychiatric element. More than one-half of the soldiers who applied in one month for assistance at the Red Cross Home Service Bureau in a large city showed marked evidence of a maladjustment which had existed in both their military and their pre-war life. Of these a considerable number showed definite symptoms of mental instability. To deal with them effectively requires an examination by a skilful psychiatrist who should diagnose the condition and direct the worker in her task of supervision and reconstruction. These soldiers must be saved from unsuitable work or more destructive idleness and gradually reëducated to assume their responsibilities. This war-time problem is not a new one. It is simply a thrusting into the limelight of conditions dimly perceived before. There exist always in the community a number of people who manage with difficulty to bear up under adverse conditions of life. Faulty environment or ill-suited work provides a wearing process that brings catastrophe. Timely advice and assistance from psychiatrist and social worker will often remove difficulties and give relief.

In a country that draws so many of its inhabitants from the Old World there occur many cases of lonely people for whom no one feels responsible when mental disease is seen to be developing. Employers and landladies wash their hands of responsibility when work and money are not forthcoming, and the confused irrational man or woman does not turn to ordinary channels for help. It takes a comprehending social worker to appreciate the needs and dangers of this condition and to initiate efforts to get it under control. If such a specially trained worker is known to be available in the community, some one finally brings the problem to her.

The owner of a rooming house reported that an Englishwoman in one of her rooms had been heard talking to herself all night, seemed confused and exhausted, and apparently was nearly starving. Efforts for a few weeks to restore her through food, friends, and work were not successful because of her peculiarities, which steadily increased. A psychiatrist diagnosed the condition as dementia praecox. The patient showed marked delusions and had hallucinations of hearing which centered about a casual acquaintance, a decent mechanic. Very soon she was trying to put detectives on his track and struggling desperately against the influence of his supposed voice.

She was very reticent, but finally her story came to light. She belonged to a prominent English family, now reduced in wealth, and had been a governess in her youth. Unfounded ideas of the significance of ordinary courtesies shown her by a curate, together with annoyance at her family's efforts to make her see reason, soon increased her early eccentricities of behavior. She left home against advice and came to this country without money or friends or prospect of work, and for five years had kept up a losing struggle for existence, always hampered by her suspicions. Her conduct finally became so troublesome that, on the doctor's advice, she was placed in a private hospital by the psychiatric worker until her family could be notified. They were filled with gratitude for her care, and permanent arrangements were soon made. Her sister has twice come to this country to assure herself of the care given, and will take her to England now that the war is over.

A young Polish girl who was without relatives in this country, but who had worked as a servant here for five years, became deranged, full of fears, and twice tried to kill herself. For some weeks, while doctors were unable to agree about her condition, a psychiatric worker kept her under supervision and arranged for temporary work. Later, when the symptoms became unmistakable, the worker secured her admission to a state hospital, and had a guardian appointed to protect her savings.

All these types of cases make up the great group of those who need preventive measures or early treatment to control their condition. There is also another group who need advice and supervision that can be given only by some one who understands their needs. These are the patients discharged from hospitals for mental disease, able to come back to family life and to begin slowly to pick up the thread of normal living. The patient's family must be taught how to receive him—neither as an object of suspicion nor as differing from themselves. Some guidance must be given in dealing with such minor peculiarities of conduct as may yet linger. A right atmosphere in the home will do much to make recovery permanent. Readjustment is gradual, and difficulties arise that do not trouble the mentally stable. Ignorant prejudices of the public must be overcome, and the patient's confidence in himself restored. Suitable occupation must be found; mental backsliding must be prevented. This service for former patients is known as "after-care," and is daily proving its value in work done for many state hospitals. It must be given by some one who is alive to the special needs of such convalescents and who knows how to utilize for them the resources of the community. Where state hospitals have their own social workers, this phase of the work more properly belongs to them, but very few state hospitals are so provided as yet.

How shall one find the incipient cases? Comparatively seldom do they ask for assistance themselves. It is through social and industrial channels that the worker must seek them out. A brief explanation of the possible causes of abnormal conduct and of the early symptoms of mental breakdown will enlist assistance in locating them. Church visitors, school-teachers, settlement workers, factory overseers and foremen, club leaders, district nurses, police matrons and inspectors, city-court judges, probation officers, truant officers, charitable organizations, playground supervisors, clergymen, all will find occasional need of the psychiatric social worker's services in some unusual situation; medical men will gladly turn to her for the supervision they have not time to give a neurotic patient, and because of her mental hospitals will be able to return more quickly to family life the patient who still needs supervision.

While this worker for the mentally disabled stands ready at all times to give her mind and heart to the service of those who are ill, she may make a yet bigger contribution to community welfare. Prevention of mental disease can best be achieved by spreading knowledge of the preventable causes. Many opportunities can be secured by the worker to tell local clubs or societies of the disastrous results of alcoholism, syphilis, and drug habits in producing insanity, and of the influence of heredity in increasing the number of the feebleminded. The mental health of the community will be promoted in proportion as these dangers are known and avoided. The researches of the world's foremost psychiatrists have taught us the danger signals and the pitfalls in mental development, and a psychiatric worker will feel her responsibility to disseminate this knowledge.

To do effective work in a community, a psychiatric social worker must have opportunities for securing the advice of a psychiatrist. Only with his diagnosis and advice can she safely plan her course of action. Very many of her patients will not be able to pay for the services of a specialist. Very many could not be persuaded that their condition justified such an outlay. A free mental clinic is therefore an essential if the worker is to have the scientific basis she requires in dealing with these difficult individuals. On the other hand, a mental clinic cannot be very valuable without a social worker. Without a clear picture of the personal, social, and economic surroundings of a patient, it is often difficult for the psychiatrist to make a diagnosis or to outline a course of treatment. It is also of little use to diagnose and prescribe unless there is a prospect of the directions being carried out intelligently.

What, then, should we say are the functions of a community worker for mental cases?

To search out individuals who show evidence of serious nervous and mental strain and to induce them to secure competent advice;

To regulate the activities and surroundings of those incipient cases whose threatened breakdown may be prevented by prompt compliance with the psychiatrist's instructions;

To break down the existing prejudice against hospital treatment for those whose condition demands it;

To assist those who must obtain hospital care by carrying through the often involved legal proceedings necessary to obtain it;

To act as the friend of the mentally ill who may be friendless, giving them the protective care ordinarily given by the family;

To supervise and reëstablish in normal life patients discharged from mental hospitals;

To act as a medium for the education of the public in the prevention of mental disease and defect and in the general rules of mental hygiene.

If we are to deal more effectively with this great problem of mental disease and defect, we must multiply those agencies which offer prompt aid in conditions of mental abnormality and which promote prevention. We must see established many more centers for advice to the neurotic and the psychopathic. We must place within their reach the necessary help of the psychiatrist and of his assistant, the psychiatric social worker.

PLACE AND SCOPE OF PSYCHIATRIC SOCIAL WORK IN MENTAL HYGIENE*

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THE history of the evolution of civilization demonstrates that progress is due fundamentally to the development of the intellect in mankind. As man has advanced intellectually, he has acquired, increasingly, capacities for perceiving problems of deep significance to himself and to the general welfare, and has striven to find means for solving them. The advancement of society depends upon the intellectual level of the people. Progress takes place in proportion to man's capacity for conscious appreciation of his needs and in accordance with his ability to discover resources capable of meeting them.

Leaders of all ages have been persons of superior mental caliber. Our greatest leaders have been those individuals who not only have contributed to society intellectually, in the narrow sense of the term, but who have expressed in their lives great moral and spiritual strength. We recognize these and allied characteristics as qualities of mind—as expressions of a superior intelligence—and realize that it is through the expansion of these attributes of mind that man advances and the evolution of the race takes place.

In the course of cultural advancement there have been sporadic efforts on the part of men and women to search into the mysteries of psychic phenomena and to explain mental life. Scientific study of the mind from the angles of psychology, sociology, and even the physical sciences, made little progress until the nineteenth century. It is only within recent years that our knowledge of the mind, either in health or disease, has been sufficient or comprehensive enough to enable us, in the group sense, to recognize that our problems, discussed from any angle we may choose, are traceable in a great measure directly to the state of mentality of the individual or the group, that our *greatest* need is a more extensive knowledge of our mental capacities and limitations and a greater understanding of how best to conserve our mental powers, since upon our mental health depends our national strength and future progress.

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Conservation of mental health—in other words, mental hygiene—is not a new idea to any of us, but it has been a subject that has not been given sufficient emphasis in the past. To-day more than ever before it is of concern to a larger group of people whose interests primarily are along other lines of endeavor; it is becoming of more universal interest than one at first realizes. This has undoubtedly been due to two causes: first, the attention attracted to the subject through the mental hygiene educational propaganda, the wider circulation of publications of scientific studies especially relating to social psychiatry and allied subjects; and, second, the national need for assistance in solving present-day problems, both those of the community and those of the individual.

The increasing complexities of modern life demand an ever-increasing "speeding up" of the mental faculties in order to meet the requirements of the times. The result of this high-pressure activity upon the people is demonstrating itself in many ways, of which incomplete adaptation to environment is the most conspicuous. We may lay much of the present-day restlessness, discontent, uncontrolled manifestation of emotion, faulty judgment, and blind reasoning to war conditions, and a great deal can be said in favor of this view; but an analysis of conditions before war times shows the same upward curve in these characteristics. The public registered itself then as it is doing now in its behavior. Statistics, as well as our personal observations, indicate an increasing number of so-called "nervous and mental breakdowns." We note also the tendency of many supposedly intelligent persons to disregard their mental health completely. This tendency is shown in the lives of many of our prominent men and women, by their unwise expenditure of effort, their exaggerated state of emotional tension, and their haphazard mode of living—the little time reserved for reflection, repose, or adequate rest and the almost abnormal craving for emotional excitement. The people of to-day—I speak of pre-war times as well as of the present—are seldom in their homes, and when they are, little time is spent in preparing for "to-morrow." One may ask, "Why lay these problems all at the door of the mind?" and the answer comes, "Because it is the mind that either controls or does not control the activities of man."

The world war quickened the intelligence of most of us. It presented problems that of necessity created capacities for solving them. Our social consciousness expanded more fully during this short period of time than could have been otherwise possible. Man became less conscious of his own welfare and more aware of his obligation to his neighbor or his country. With this advancement came the need for conservation. In his eagerness to be of service, man neglected himself. His rushing forward, so to speak, had its disadvantages as well as its advantages, for the stimulus and the resulting activity sometimes proved too great; we need only to look around us to observe its effects. This emotional instability denotes a crying need for mental hygiene.

That in mental hygiene we have discovered the panacea for all our mental ills and that the application of the principles already evolved will prevent future functional disorders or mental disease, or even allay present-day conditions, is, of course, not true. We have still a long road to travel. But a brief survey of recent activities shows that mental hygiene has taken great strides and that it stands as one of the foremost educational movements of the day.

We know that the national and state committees have culled from scientific literature material of value to the mental welfare of the people; that this literature, which is rich with information concerning the factors that contribute to nervous and mental invalidism, has been given a wide circulation; and that it has paved the way for a more comprehensive understanding of our community problems, thereby opening new avenues of thought through which we may arrive at more adequate methods for protecting our mental health.

The achievements of this educational campaign are manifold. The results are felt not only by educators, but by the general public. They clearly indicate the public's trend of thought and show that the people are analyzing intelligently their community problems and are finding the ways and means for meeting them. Already, in many states, bills have been passed providing for more adequate care and treatment of the mentally handicapped; in addition, efforts are being made to secure legislation that will place upon the state the responsibility for the indeterminate care and supervision of those individuals whose lives and histories demonstrate their inability to adjust themselves to community life. Emphasis has also been placed upon the necessity for provision by the state of adequate facilities for the early examination of individuals who show only slight neuropathic or psychopathic tendencies, and for the institution of mental clinics.

It is quite probable that we are on the threshold of still greater achievement, for the workers in the fields of medicine, psychology, and sociology are contributing data of immeasurable value to students of mental hygiene.

The literature of these allied professions shows their realization of the interrelation and interdependence of their respective fields. It shows that the problems we hope to solve have their roots deeply imbedded in the soil of all three sciences, and that the adjustment of conditions depends largely upon the combined efforts of them all. These conclusions are suggestive only, but they indicate that we have already gained a broader conception of our work which will eventually result in a deeper understanding of mental life and a more skillful handling of our subject.

Mental hygiene has paved the way for the prevention of many of our organic nerve and mental diseases, but we are still far behind in our understanding and control of the functional disorders of the nervous system—the psychoneuroses, those nervous states that are characterized principally by manifestations of emotional disturbances, recognized as one of the most intangible of disorders and most prevalent in modern times. We have abundant data on the symptoms of these conditions, have developed our diagnostic nomenclature, have isolated many causal factors, and have made progress in our knowledge of the nature of their constituent parts. As an outcome of these discoveries, the emotional life has become the center of attention, and greater importance has been placed upon the value of research in relation to the psychology of the emotions. It is social psychiatry that has been responsible to a great extent for the unfoldment of these truths. Should we not look to it for continued leadership in the future?

Social psychiatry we may define as that branch of medicine which deals primarily with the psycho-social aspects of mental and nervous disease, thereby extending the field of psychiatry into those of sociology and psychology, in so far as these sciences contribute to a clearer understanding of the various phases of mental abnormalities and affect their treatment.

Psychiatric social work came into being at first as a subdivision of medical-social work, but is now recognized as a separate division of social work. Psychiatric social work may be descriptively characterized as a laboratory in which the field workers of mental hygiene, through the medium of the so-called "social case-work method," study and treat the social-psychological maladjustments which have a definite relationship to mental disease. The work is primarily that of individual service for those who suffer from the various forms of nervous and mental disorders. The material is obtained from personal contact with these sufferers, from their families, physicians, and employers, from school and public authorities, and from public and hospital records.

The students in this workshop are individuals whose natural gifts, combined with education, training, and experience, equip them to discern intelligently, quickly, and accurately, in the vast mass of psycho-social material at hand, those facts which are of value to psychiatry. These students are thus qualified to act as consultants and assistants to neuropsychiatrists not only in bringing to them data of diagnostic interest, but in aiding them in their treatment of disorders which indicate a need for a readjustment of social conditions or for personal reëducation.

In presenting psychiatric social work as a laboratory for field workers in mental hygiene, we give it a strategic position that to a certain extent establishes its relation to mental hygiene.

The value of this work cannot be estimated wholly in terms of fact, owing to its being still in the experimental stage of development, but we conclude from observation and from reports of its activities that its field of operation is rapidly expanding, that it is contributing to our knowledge of the social causes of nervous and mental disease, and that the field workers, through their personal contacts, are reaching those individuals in the community who, because of their lack of advantages or mental equipment, would not otherwise have access to such help as mental hygiene can offer them.

In order to obtain a clear conception of the scope of activities in this field, it will be helpful to survey briefly some of its accomplishments.

In the study and treatment of dispensary patients who suffer from the so-called functional disorders of the nervous system known as neurasthenia, psychasthenia, and hysteria, psychiatric social work has made a definite contribution.

Until recently these patients did not receive sufficient attention in the out-patient departments of our hospitals, owing to the fact that their disorders were looked upon more or less lightly by physicians. In addition, the pressure of clinical duties, the many cases demanding attention, made it necessary, in general, for the clinic physicians to confine their efforts to organic disturbances of the nervous system. With greater knowledge of the causes of functional disorders grew the conviction that these conditions were of the utmost significance to their victims and to society at large; that it was important to study and treat them from the social and psychological, as well as from the medical, standpoint. As a result of this broader conception of therapy, social workers have been placed in a number of neurological and mental clinics to establish an adequate coöperation between medicine, as represented by the physician, and environmental conditions, as represented by the social worker.

In supplementing the physician's work in the study of the psycho-social maladjustments that have a bearing upon the invalidism of these patients, and aiding in the readjustment of these when possible, the social worker uses the social case-work method in investigating the patient's environmental conditions, hereditary influences, and temperamental tendencies. The method is used to secure data to assist the physicians in rounding out their clinical examinations and thus make it possible for them to give more adequate advice as to treatment and procedure in the reëducation and reëstablishment of the patient.

It is impossible at this time to estimate the importance to the mental hygiene movement of the reëducational work of the psychiatric social worker, but a study of the social records of sufferers from these nervous disorders shows progress along curative lines and reveals certain points of interest.

The patients who receive the most benefit are those whose mental condition is good, but whose physical and mental environment has been extremely poor. These patients are eager for help and respond readily to treatment. Many have been groping blindly for health and simply need to be given a few fundamental facts about their mental attitude in order to evolve for themselves a workable philosophy of life. Others have serious character defects which are difficult to adjust, but with the encouraging guidance of the physician and the social worker, they gain self-reliance and a healthy mental attitude.

Patients whose mental equipment is not very good and whose environmental circumstances are poor do not respond so well, but it has been found that, through careful supervision and with assistance in the readjustment of their home conditions, progress has been made, though only in a palliative sense. There is a large group of patients who, because of constitutional weakness, have not the stamina to gain any help through this method of treatment, but it has been possible to help them through the coöperation of relatives and others. In a case of this kind the psychiatric social worker instructs the relatives in the principles of mental hygiene, gives them a better understanding of the patient's condition, and stimulates their interest in helping him.

It seems reasonable to conclude that prevention of these disorders depends to a large extent upon adequate early training, for when they are finally analyzed, it appears that they are the expression of faulty character development and habit formation.

In the care and treatment of the insane and the feebleminded, psychiatric social work has made for itself an important place. It is hardly necessary to mention that adequate treatment of these patients depends upon their receiving suitable community supervision, and that it is of primary importance to detect cases early in their development.

Psychiatric social work is making this early treatment possible. The social workers are supervising the patients who are not suffering from severe mental disorders and who are living in the community. They are acting as counselors to their families, teaching them how to care for these patients intelligently, and showing them the need for suitable employment and for conservation of mental and physical health.

Many of the state hospitals for mental disease, the schools for feebleminded, the courts and reformatories, have attached to their staffs psychiatric social workers who are aiding the physicians in diagnosing difficult border-line cases by securing past personal and family histories. The workers are also supervising patients who have been discharged or are on parole from these hospitals. This work needs no explanation. It is valuable as it means among other things more immediate segregation, when this is necessary, better supervision, and better care for the mentally disabled.

In the field of research psychiatric social work is making some headway as is shown by the social data being published by various workers as a result of their work.

An intensive study of the economic efficiency of one hundred epileptics who received treatment in the neurological clinic at the Massachusetts General Hospital in Boston has revealed a number of interesting facts that have been overlooked by the medical profession and by community-welfare promoters.

The study shows that a large percentage of epileptics of working age support themselves and even contribute to the support of their families. It is exceedingly important that the full significance of this fact should be appreciated, for in the opinion of many persons, laymen and physicians alike, the mental capacity of epileptic patients is rated as distinctly low; most institutional data hitherto at our disposal have seemed to emphasize this fact. The investigation shows, as well, that these patients are compelled to change their work frequently because of their handicap—the seizure or attack—that they are often obliged to accept work that is uncongenial and sometimes inferior to their capacities, and that the length of their service depends more upon the lack of attacks than upon their efficiency or the character of the occupation. The majority of patients who are not self-supporting—those doing unskilled labor principally—would be able to contribute far more toward their own support if they did not so often lose their work on account of their attacks.

Patients who have frequent or severe seizures generally lose their positions, no matter how great their suitability may be in other ways. Employers discharge them in most instances as soon as their handicap is discerned. Employers and fellow workmen are rarely, if ever, willing to take the responsibility of looking after their companions at these times, and are often seriously alarmed by the occurrence of the attacks.

These observations indicate that a large number of community patients have sufficient economic efficiency to earn a living if placed in suitable positions and relieved of the fear of losing their work. It appears that this continual anxiety concerning their positions is a greater factor in their mental deterioration than has been supposed, and that work is helpful as a therapeutic measure, if for no other reason. In consideration of these facts, it seems advisable to bring about some sort of coöperation between employers, the medical profession, and all who are interested in preventive measures, in order to plan for more adequate care of epileptics. Epileptics should certainly have the same opportunities as the physically handicapped, and there seems to be no reason why the less handicapped epileptics should not remain in general community industries. For those epileptics who have severe seizures, necessitating special conditions, opportunities, shops, might be provided in connection with the institutions that care for these patients.

The study also shows that epileptics of school age are frequently debarred from school on account of their attacks, although their scholarship has been reported as above the average. This suggests the need of providing in suitable ways for the adequate instruction of certain groups of epileptic children. Vocational education is suggested for those children who, because of their physical or mental equipment, cannot follow a school course, but who are not so ill that they need institutional care and are capable of being trained to support themselves, at least partially.

The part that psychiatric social work played in the army is indicated by the fact that it served primarily the neuropsychiatrists in the military hospitals as a medium through which they could obtain the past personal and family histories of soldiers suffering from war psychoses and neuroses. The advisability of placing specially trained social workers in military hospitals for soldiers suffering from these conditions was early recognized. It was more forcibly brought home when the men began to return from overseas, for many came with reports that contained very little medical information; not infrequently they came only with a diagnosis. As some of these cases presented symptoms which indicated that their condition had probably existed for years, if not from birth, and others came with a diagnosis of epilepsy, but had no seizures while in the hospital, these investigations frequently played an important part in the disposition of the cases.

The histories were secured through correspondence with relatives, family physicians, employers, schools, etc., and were used for diagnostic purposes and also to determine whether the soldier's condition occurred in line of duty.

It is interesting to note that histories were obtained in 90 per cent of the cases referred for these investigations at the military hospital for war neuroses at Plattsburg, New York, (U. S. Army General Hospital, No. 30). The majority of the replies were of value not only from a medical standpoint, giving the hospital authorities a clearer insight into the present condition of these soldiers, but from a sociological standpoint, showing the environments from which they came. A large percentage of the reports definitely placed the soldier's condition as not occurring in line of duty, but gave a clear past history of nervous and mental disorder.

Another phase of service was that of securing for these discharged soldiers adequate after-care through the Home Service sections of the American Red Cross. The nature of their disorders required supervision of a special character, but owing to army regulations, it was impossible to give civilian organizations the medical information essential for the adequate handling of these cases. The after-care was, therefore, considerably crippled in its efficiency. The effectiveness of treatment of these disorders, in military as well as in civilian hospitals, depends upon the support and coöperation of the community after the soldier's or patient's discharge. Unless the organizations that have been given the responsibility for their after-care have a clear understanding of the medical as well as the social aspects of the cases consigned to their care, the results cannot be effective.

This, briefly, is a statement of the present place and scope of psychiatric social work in mental hygiene. It outlines a number of the activities and achievements of the work and in a measure indicates its value to the mental-hygiene movement.

Psychiatric social work is contributing to the advancement of social psychiatry in serving as an aid to diagnosis and as a guide in treatment.

The social records show data of social and psychological value in research in nervous and mental disease.

The future place and scope of this work in mental hygiene we do not know, but the reëducational work which is being done by psychiatric social workers is significant and indicates that this work will extend its scope of usefulness along curative and preventive lines.

CURRENT MISCONCEPTIONS REGARDING REFORMATION

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ASIDE from the minor mistaken ideas on the subject of reformation entertained by both offenders and some of their would-be friends and advisers, there are two major sophistries which defeat the good intentions of those holding them. No one may expect to reform who believes that (1) it is possible to do so without a long period of practicing reformation, and (2) that much help in reformation is available outside the offender's own thinking. In other words, the two commonly held, but damaging misconceptions regarding reformation are that a wrong method of living can easily be changed to a right one whenever the attempt is made, and that serving a short sentence in a reformatory will somehow "reform" one.

The favorite metaphor used by unthinking advisers of offenders is "turning over a new leaf." The idea is an unfortunate one and very ill chosen, for by it the impression is conveyed that a simple act of the will is sufficient to cover up the past and its effects on character and habits, and that one has only to try to do well in order to be reformed. The fact is that reformation is a long, hard, discouraging process which must be *practiced* intelligently—and successfully—for a long time before one may begin to have confidence in one's self-control and ability to resist temptation. Far from discouraging attempts to reform, however, knowledge of these facts should be a source of encouragement, a spur to setting about the undertaking in the right way. Knowing the task ahead to be long and hard, the sensible person will seek a good method, thereby, if he have adequate determination, many times multiplying his chances of success. If one attempts to lift an object thinking it weighs thirty pounds, when it really weighs three hundred pounds, one's first attempt will fail.

An analysis of the steps taken, consciously or unconsciously, by one who reforms is helpful and conducive to clarity. Many have reformed without analyzing the process; nevertheless, they have taken unconsciously the mental steps to be outlined. The first and essential mental activity, apparently, is a *feeling of regret* for the damage done oneself and others by ill-chosen acts.

The next logical step is the *intention to do better*. What should be the next step in the mind of one who regrets wrongdoing and intends to do better? It is *to make a plan* for better thinking and acting.

This third step needs some elaboration. All offenders, when at their best, take the first step above indicated; most of them take the second; but very few take the third. The first step is a mere feeling; the second involves some thinking and something akin to purposefulness; but in making a plan, the third step, constructive thinking is necessary. One may intend to build a house or a steamship, but unless one goes further than intending to do it, there is no tangible result. Now a plan of anything worthy, be it house or steamship or a proposed new law, may be made to look well on paper—i. e., in a drawing or in writing or in print. When we stop to think of it, every good and successful project has been reduced convincingly to written schemata before it was undertaken. Every aëroplane is carefully drafted before being built. Every bill presented to the legislature for consideration is carefully drafted beforehand. Yet many lives are lived without being planned, much less having the plan written out. To change a life over in the formative period (an almost impossible task after the close of that period—roughly estimating, after the age of twenty-five) is a far harder task than to live a good and successful life from the start. It is highly important, if one attempts to change one's life over, that one avail oneself of every help within reach. A written out—and of course carefully thought out—plan is a very great aid, probably the very best material and secular aid to reformation one may have, since it is about the only always sure means of success. If one has a definite plan, one knows how one may change one's life over in time, if one does not depart from the plan.

In making the plan, one should write down a well-formulated outline of living to cover a considerable time—three, four, five years—during which time one is to practice one's good intentions. It takes four years to secure a collegiate education—which makes something of a change for the better in one's life. Offenders have usually been several years on the downward course before they even start, in a prison, to think of reformation. If it takes five years to form the bad habits of thinking and acting that put one behind the bars, it will take at least as long to unlearn the evil and take on the good habits of life. Or, from another viewpoint, one year is not long enough to practice on one's plan for a new and better kind of life; ten years is too long a period, probably; it would not be possible the first time to look ahead definitely so far. But in five years, lived according to a good plan, one could learn a trade, advance a neglected education, become one of a group of good associates and friends, accumulate a small bank account, and advance far on the road to reformation, all at the same time.

Obviously, however, this could not be done without a plan. By writing out a tentative plan in the beginning and adding to it and striking out from it and rewriting it again and again, scores of times, perhaps—in fact, each time that new and better ideas could be introduced—one would in the end have a plan to be proud of and one that would best fortify him, secularly, against yielding to the temptations he is sure to encounter.

Having made a working plan for a successful life, then, what is the next step to be taken toward reformation? Very few offenders of whom I have asked this question have given a correct answer. A superficial and often mooted answer is, "Go out and live the plan." To regard the above as the next stage would be to overlook a very important step, the fourth—i. e., to *decide* whether to adopt the plan and to *determine* to adhere to it and work it out as planned. Here is something more than thinking and far more than feeling: decision and applied will power—decision to deny oneself pleasure in order to begin progress and determination to stick to a good plan and let nothing turn one aside from it. The last step is obvious—*to live the plan.* This requires long-continued, well-chosen action and is the hardest of all the steps to take, just as the first was the easiest. A summary of the five steps in reformation may be expressed as follows:

1. A feeling of regret for unworthy living;
2. The intention to live more worthily;
3. The making of a plan by which to be guided;
4. The deciding and determining to adhere to the plan;
5. Living by the plan for the time set.

To the ignorant and thoughtless this seems a needlessly hard program; as they are not in the habit of undertaking hard tasks, they seldom undertake this one, though it is the only plan that promises success. The weakling allows himself to accept some makeshift device which seems easier, but is likely to fail. Reformation is a long, hard, uphill process, and he who deludes himself with the thought that he can "turn over a new leaf" any time he chooses to do so is making a costly mistake. The older a person is, the harder is the process of reformation and the greater the likelihood of failure in the attempt.

Reformation must be a self-wrought process. It cannot be imparted from without. No reformatory or other agency outside the offender's own mind can reform a personality. Reformatories and other agencies for reformation may indirectly assist, may prepare for reformation, but they cannot accomplish the reformation. The coöperation and self-denial of the one to be reformed are essential. A high school is a good place in which to prepare for a college education, but it is not a good place in which to acquire the college training. A modern reformatory is well adapted to prepare an offender for the reformation he must plan out and work out for himself, just as the high-school boy plans out and works for his college course. No college student ever got into college who didn't plan to go, determine to go, and then stick to his plan for going for a long time, denying himself the pursuit of pleasure in order to make progress.

Only the well-equipped mentally may hope to succeed in self-reformation. This is a hard fact to face. Lest it should seem that all but normally or supernaturally equipped offenders are debarred from again living worthily because of the difficulties of reformation, we suggest that those of limited mental capacity—those who cannot meet the demands of the above five steps or the demands of society upon them—might be more slowly trained or retrained by being kept for a sufficient length of time in a suitably equipped institution, somewhat like a reformatory, where they would be able to form new and better *habits* of thought and action. In some cases at least we could expect this method to enable restoration to community life. The experience of educators of the feebleminded has shown that habit formation may be depended upon in some cases, deviate in character, to make them capable of returning to their families, after a sufficient term of training.

At present there are no institutions of the kind above indicated for "defective delinquents," but before many years we shall have them. Our laws now sentence those mentally incapable of self-reformation with those capable thereof, and for the short terms adapted only to the preparation of the latter for self-reformation; but eventually our laws will enable the commitment of mental weaklings indefinitely to institutions adapted to their long training in correct habits of thought and action. This will be, probably, the best expedient both for them and for the community.

PSYCHOPATHIC CLINIC OF THE CHILDREN'S COURT OF THE CITY OF NEW YORK

SECOND ANNUAL REPORT*

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DURING the year 1918, the second year of its work, the Psychopathic Clinic of the Children's Court of New York City made a careful mental and physical examination of 1,082 children sent to it from the city's five children's courts. In the Brooklyn clinic, established in the Brooklyn Children's Court, 327 cases were examined. Of these, 305 cases came from the Borough of Brooklyn and 22 from the Borough of Queens. In the Manhattan clinic, 755 cases were examined—684 from the Borough of Manhattan, 63 from the Borough of the Bronx, and 8 from the Borough of Richmond.

To carry on this work, the Manhattan clinic has had the services of one full-time physician, one part-time physician, one psychologist, and two social workers, while the Brooklyn clinic has had one physician on half time, one psychologist, and one social worker. This work was made possible by the generosity of the National Committee for Mental Hygiene.

METHOD OF CHOOSING CASES FOR EXAMINATION

During the year the judges continued to send to the clinic those cases which they recognized as not being normal mentally or as presenting problems which they desired to have carefully studied. The probation officers also brought children who in their opinion needed to be examined. Some cases were received from the Big Brother and Big Sister organizations, and, in Brooklyn, from the Brooklyn Juvenile Protective Association.

The report of the clinic for the year 1917 pointed out the need of work on the problem of recidivism, and during 1918 a detailed study was made of the cases of 268 recidivists, the results of which are stated in a special section of this report.

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* Report submitted to the Honorable Franklin Chase Hoyt, Presiding Justice of the Children's Court of the City of New York.

CLASSIFICATION

At the beginning of January, 1918, the clinic adopted a classification for its cases that followed as closely as possible the classification adopted by the American Medico-Psychological Association and used by the National Committee for Mental Hygiene in its Bureau of Statistics. It incorporated in this classification the large group of retarded cases. The classification stands as follows:

1. Normal Group

Of these cases there were 192 or 17.8 per cent.

2. Retarded Group

This group includes those children who are not feebleminded, but who are retarded mentally in consequence of physical defects or poor environmental conditions, such as language defects, lack of opportunity, etc. Of these there were 362 cases or 33.5 per cent. For many of these children with physical defects arrangements were made for treatment in the various hospitals and clinics.

3. Mental Deficiency Group

This group includes:

(a) Morons

Those individuals who are capable of earning a living under favorable circumstances, but are incapable, by reason of a mental defect that has existed from birth or from an early age, of competing on equal terms with their normal fellows or of managing themselves and their affairs with ordinary prudence. Of these there were 304 cases or 28.1 per cent.

(b) Imbeciles

Those individuals who are capable of guarding themselves against common physical dangers, but are incapable, by reason of mental defect that has existed from birth or from an early age, of earning their own living. Of these there were forty or 3.6 per cent.

4. Constitutional Psychopathic Inferiors

This group includes those cases that have a congenital defect in the emotional or volitional fields of mental activity which results in inability to make a proper adjustment to the environment. Of these there were fifty-four or 4.9 per cent.

5. *Psychotic Group*

This group includes the following psychoses:

- Psychoses with mental deficiency
- Traumatic psychoses
- Toxic psychoses
- Juvenile paralysis
- Dementia praecox
- Manic-depressive psychoses
- Undiagnosed psychoses

Of these there were forty-four or 4.1 per cent.

6. *Psychoneuroses and Neuroses*

This group of cases includes those disorders which are essentially psychogenic in nature. Of these there were sixty-two or 5.7 per cent.

7. *Epilepsy*

This group includes those cases characterized by attacks in which there is a loss of consciousness with a succession of tonic and clonic convulsions. Of these there were twenty-four or 2.3 per cent.

GENERAL STATISTICAL CONSIDERATION

Of the 1,082 cases examined, 82 per cent were classified in terms of deviation from the normal as follows:

	Total	*Boys*	*Girls*
Mental defectives	344	233	111
Constitutional psychopathic inferiors	54	31	23
Psychotic	44	25	19
Psychoneuroses and neuroses	62	49	13
Epilepsy	24	18	6
Retarded	362	295	67
	890	651	239

AGE

The ages of these children varied from six to sixteen years. There were a few cases brought into court for improper guardianship that were between three and six, and a few over sixteen years that were on probation and had been returned to court for violation of their probation. The age at which the greatest number of boys were arrested was fourteen years, while that of the girls was fifteen years. One of the reasons for this difference is the fact that girls are less acquisitive than boys, but as they grow older are more prone to become involved in sexual offenses. This is shown more clearly in the table on types of offenses.

ENVIRONMENT

Of the 1,082 cases, 403, or 37.2 per cent, had a favorable environment; 539, or 49.8 per cent, had an unfavorable environment; and in 141 cases, or 13 per cent, the environment was unknown. The percentage of mental deviates having an unfavorable environment was 49 per cent, thus showing that while mental deviates are not inherently criminal, yet when exposed to an unfavorable surrounding, they are unable to resist and tend to become addicted to crime.

NATIVITY

Of the 1,082 cases, 878, or 81.1 per cent, were born in the United States. One hundred and ninety-eight cases, or 18.3 per cent, were foreign born; of this number fifty-three were born in Italy and thirty-nine in Russia. The nativity of six was unascertained.

	Total	*Boys*	*Girls*
Native born	878	646	232
Foreign born	198	139	59
Unascertained	6	6	0
	1,082	791	291

HEREDITY

Of the 1,082 cases, 418, or 38.6 per cent, had an unfavorable family history; 459, or 42.5 per cent, had a favorable family history; 67, or 6.1 per cent, had a doubtful family history; and in 38 cases, or 12.8 per cent, the heredity was unknown. The heredity was considered unfavorable when syphilis, insanity, mental deficiency, epilepsy, tuberculosis, or alcoholism was found among the ancestors. Among the mental deviates, 349, or 40 per cent, were found to have an unfavorable heredity, while among the normal cases 69, or 35 per cent, possessed an unfavorable heredity.

TYPES OF OFFENSE

The offenses in the Children's Court are classified under the two headings "Juvenile Delinquency" and "Special Proceedings."

Under Juvenile Delinquency are grouped all offenses against persons, property, and peace. Under Special Proceedings are the improper-guardianship cases and cases of ungovernable and disorderly children. Of the 1,082 cases, 393, or 36 per cent, were cases of Juvenile Delinquency; 623, or 57 per cent, were cases of Special Proceedings; and 66 were those who did not appear in court.

The cases examined during 1918 showed no increase over 1917 in the number either of improper-guardianship cases or of disorderly children. The number of such cases for 1918 was, in fact, a trifle lower than for 1917.

	Total	*Boys*	*Girls*
Juvenile Delinquency	393	363	30
Special Proceedings			
Improper guardianship	145	80	65
Ungovernable or disorderly children	478	299	179
Others	66	49	17
	1,082	791	291

RECIDIVISM

The following is a brief study of the 268 recidivists who were received for special study during the year 1918.

A recidivist is defined in the Children's Court as a child who has a previous court record. It has long been recognized by criminologists that the repeated offender or recidivist constitutes the most important problem for prisons and reformatories all over the country, and it has been agreed that almost all confirmed criminals show plainly their tendencies by at least late childhood. Therefore, it is in the Children's Court that these repeaters can first be weeded out and efforts made for their readjustment before they have reached the age and condition at which they become a menace to society.

The report of the Special Committee of the State Commission of Prisons shows that 60 per cent of the population of all penal and correctional institutions have served previous commitments, and that in studying chronic criminalism the most important single factor discovered is the abnormal mental condition of the repeaters; 50 per cent of them are mental deviates, of whom 30 per cent are feebleminded.

The 268 children dealt with in the following report were unselected cases, except for the fact that they were recidivists. They were chosen primarily from the Manhattan court and merely represent a group which the clinic was able to study in addition to its regular cases. They do not by any means constitute the total number of recidivists who passed through the Children's Court during the year 1918.

After examination these cases were classified as follows:

Of the 268 recidivists, 39, or 14.5 per cent, were normal; 110, or 41 per cent, were retarded; 73, or 27.3 per cent, were feebleminded; 18, or 6.7 per cent, were constitutional psychopathic inferiors; 8, or 3 per cent, were psychotic; 17, or 6.3 per cent, were psychoneurotic; and 3, or 1.2 per cent, were epileptic.

The following facts were elicited from a careful study of each group:

Normal Cases

Of the thirty-nine normal cases, thirty-two were boys and seven girls.

(a) Intelligence

In studying their intelligence, the Sanford revision of the Binet-Simon scale was used. According to this scale, the grade of intelligence is expressed by the use of the intelligence quotient (I. Q.) which is the ratio between the mental and the chronological age. The intelligence quotient of thirty-six of these children was between .82 and 1.08, which is reckoned as normal. Two boys and one girl were found to be of superior intelligence, their I. Q. being 1.09, 1.09, and 1.22. The school history of these cases is as follows:

Grade Reached at School and Age at Time of Examination

Grade	Age								
	8	9	10	11	12	13	14	15	16
High School						2	4	1	1
8th grade							3		
7th "					1		4	1	2
6th "				1	1	5	3	2	
5th "				3	1				
4th "			1						
3rd "		1	1						

(b) Heredity

In studying their heredity, it was possible to obtain accurate information for only two generations. Only by the use of careful and intensive field investigation can information be produced by means of which definite conclusions as to the influence of heredity on recidivists can be obtained. However, the following facts are suggestive:

Alcoholism on either paternal or maternal sides in 8 cases
Tuberculosis " " " " " 6 "
Insanity " " " " " 5 "
Epilepsy " " " " " 1 case

In 68 per cent of these 39 mentally normal recidivists nothing definitely unfavorable was found in the heredity.

(c) Environment

It has long been recognized that home conditions are an important factor in determining delinquency, e. g., that the parents are separated or immoral, that there is repeated dissension in the home, that one or both parents are dead. All these conditions enter into the question. The neighborhood, too, has its definite influence; also the financial status of the family—their ability to afford the ordinary necessities for their children—and, in addition, their form of disciplining their children. In 23 cases, or 59 per cent, the circumstances were either comfortable or marginal, the moral influences were good, and the neighborhood fair or good. In sixteen cases, or 41 per cent, the following factors predominated:

In 1 case the father was dead and the mother alcoholic;
" 1 " " mother was epileptic;
" 2 cases " father had deserted;
" 2 " " " was dead and the mother had no control;
" 1 case " " " " " " stepfather cruel;
" 2 cases " mother was immoral;
" 4 " " father was alcoholic and illtreated family;
" 3 " " surroundings were poor.

(d) Physical Condition

Among the seven girls of this group, two were in excellent condition, four had slight defects, and one was suffering from severe valvular heart trouble. Of the boys, sixteen were in excellent condition and sixteen had minor physical defects.

(e) Delinquencies

Of the thirty-nine cases, thirty-two had one previous arrest, four had two previous arrests, two had three previous arrests, one had four previous arrests. Their present arrests were for:

Stealing	21 cases
General incorrigibility	18 “

Their total offenses were as follows:

Stealing	6 instances
Incorrigibility	27 “
Truancy	7 “
Larceny	23 “
Burglary	8 “
Sex immorality	4 “
Robbery	1 instance
Carrying dangerous firearms	1 “

Retarded Group

Of the 110 retarded cases, ninety-four were boys and sixteen girls.

(a) Intelligence

In studying the general intelligence of these cases, they were all found to have an intelligence quotient between .75 and .82, which is reckoned as “dull” or “border line.”

Their school records were as follows:

Grade Reached at School and Age at Time of Examination

Grade	Age								
	8	9	10	11	12	13	14	15	16
High School									
8th grade							2		2
7th “						2	5	7	
6th “				1	5	5	9	5	1
5th “				2	3	8	6	3	
4th “			3	8	6	4	2	1	
3rd “			6	4	3				
2nd “	2	3							
Ungraded			1				1		

Of these cases, fifty-six were retarded in their school grade. This condition of retardation was considered as due to physical disabilities, language difficulties, etc. Of this number, for example, seventeen, or 15 per cent, were foreign born and spoke English poorly, and 20 per cent, though native born, came from homes in which a foreign language only was spoken. Thirty, or 27 per cent, had physical defects so severe as to incapacitate them. Sixty-two, or 56 per cent, had each a number of minor defects, which, when taken with language disabilities and poor environment, could account for their retardation. It is, however, this 56 per cent whose mentality cannot be definitely diagnosed without a prolonged period of observation and an improvement of their physical condition.

(b) Heredity

The following facts were obtained concerning their heredity:

Alcoholism on either the paternal or maternal side in 15 cases
Tuberculosis on either the " " " " " 8 "
Insanity on either the " " " " " 8 "
Feeblemindedness on either " " " " " 2 "
Epilepsy on either the " " " " " 3 "

In seventy-two, or 65 per cent, nothing definitely unfavorable was found in the heredity.

(c) Environment

In forty-five cases good surroundings were found and good home influence. In sixty-five, or 60 per cent, the following factors predominated:

In 19 cases the father was alcoholic and the mother worked outside the home;
In 16 cases the father was alcoholic and illtreated the family;
In 3 cases the father was sick and the mother worked to support the family;
In 8 cases both parents were alcoholic;
In 2 cases the mother was immoral;
In 1 case the father was immoral and the mother worked;
In 1 case the mother was insane;
In 2 cases the mother was dead and the father had deserted the home;
In 1 case the mother was dead and the father was immoral;
In 1 case the mother was feebleminded and the father alcoholic;

In 1 case both parents had deserted the home;
In 1 case the father was insane and the mother had deserted;
In 1 case the mother was epileptic;
In 1 case the father was dead and the stepfather illtreated the family;
In 1 case the mother was dead and the stepmother illtreated the family.

(d) Delinquencies

Of the 110 cases, 78 had one previous court record, 21 had two previous court records, ten had three previous court records, and one had four previous court records. Their present arrests were for:

Stealing	50 cases
Arson	2 "
General incorrigibility	58 "

Their total offenses were as follows:

Stealing	22 instances
General incorrigibility	99 "
Truancy	8 "
Larceny	38 "
Burglary	30 "
Assault	11 "
Sex immorality	2 "
Arson	2 "
Robbery	4 "
Peddling	2 "
Discharging firearms	2 "

Mental Defectives

Seventy-three of the recidivists studied were of this group, sixty boys and thirteen girls. Of this number sixty-seven were morons and six imbeciles. No idiots appeared in this group because of the fact that their mental condition is so easily recognized that they are cared for by outside agencies before they become involved in delinquencies.

(a) Intelligence

In this group the I. Q. was found to be below .72. Their school grades were as follows:

Grade Reached at School and Age at Time of Examination

Grade	Age							
	9	10	11	12	13	14	15	16
High School								
8th grade								
7th "						1	2	
6th "						4	1	
5th "					3	5	5	
4th "			1	2	2	4	6	1
3rd "		1	1	2	2	3		
2nd "		1	1			1	1	
1st "		1		1	1			
Ungraded	1			2	4	5	7	1

(b) Heredity

The following factors were found in the ancestry of these seventy-three feebleminded cases:

Alcoholism on either the paternal or maternal side in 19 cases
Tuberculosis on either the paternal or maternal side in 9 cases
Syphilis on either the paternal or maternal side in 1 case
Insanity on either the paternal or maternal side in 9 cases
Feeblemindedness on either the paternal or maternal side in 2 cases
Epilepsy on either the paternal or maternal side in 5 cases

In thirty-four cases, or 46.6 per cent, nothing unfavorable was found in the heredity. It is considered that the majority of these thirty-four cases are suffering from secondary amentia, brought on by accidents, birth paralysis, or severe illness, and, therefore, not inheritable. In twenty of these cases such causes were elicited in the history. The others are doubtful cases, and the cause of their mental defects cannot be proved without more intensive study.

(c) Environment

In only 20 cases, or 27.4 per cent, were the surroundings and influences favorable.

In 53 cases, or 72.6 per cent, both the surroundings and influences were bad;
In 21 cases the father was alcoholic;
In 8 cases the mother worked and there was no supervision;
In 6 cases both parents were alcoholic;
In 1 case the father was alcoholic and the mother feebleminded;
In 1 case the father was feebleminded and the mother alcoholic;
In 1 case the father was alcoholic and the mother immoral;
In 1 case the father was alcoholic and the mother epileptic;
In 1 case the father was alcoholic and syphilitic;
In 1 case the father was alcoholic and tubercular;
In 1 case the father was alcoholic and the mother dead;
In 4 cases the father was abusive;
In 1 case the father was epileptic;
In 1 case the father was dead and the mother epileptic;
In 3 cases the father was dead and the mother worked;
In 1 case the father was immoral;
In 1 case the mother was alcoholic.

(d) Physical Condition

Thirty of the children, or 41 per cent, were in excellent physical condition, 42 per cent had some minor defects, and only 17 per cent had serious physical defects, including depressed fractures of the skull, chorea, valvular heart trouble, and tuberculosis.

(e) Delinquencies

Of the seventy-three cases, forty-six had one previous court record, eleven had two previous court records, seven had three previous court records, seven had four previous court records, and two had five or more previous court records. Twenty-four per cent of the feebleminded recidivists had four or more arrests, while only 8 per cent of the normal cases were recidivists with an equal number of arrests.

This high percentage of recidivism among the feebleminded shows that whereas a feebleminded individual is not inherently a criminal, nevertheless, when exposed to temptation in a poor environment, he becomes more easily a member of the criminal class than does a normal individual. The latest delinquencies of the members of this group were as follows:

General incorrigibility........	40 cases
Stealing.....................	28 "
Assault.....................	3 "
Immorality..................	2 "

Their total offenses were as follows:

General incorrigibility........	79 instances
Larceny....................	24 "
Burglary....................	20 "
Stealing.....................	9 "
Immorality..................	5 "
Robbery....................	2 "
Truancy....................	5 "
Assault.....................	2 "

Constitutional Psychopathic Inferiors

Of the eighteen constitutional psychopathic inferiors, fourteen were boys and four were girls.

(a) Intelligence

It was found that the I. Q. ranged between .85 and 1.00. There were no cases of superior intelligence and none that were suggestive of a border-line condition.

Their school history is as follows:

Grade Reached at School and Age at Time of Examination

Grade	Age						
	9	10	11	12	13	14	15
High School.....................							1
8th grade......................						1	3
7th "					1	2	
6th "						4	1
5th "				1			
4th "	1			1			
3rd "		1					
2nd "							
1st "							
Ungraded......................						1	

(b) Heredity

In studying their heredity, the following factors were found:
Alcoholism on either the paternal or maternal side in 7 cases
Tuberculosis " " " " " " " 1 case
Insanity " " " " " " " 2 cases

In 44 per cent there was nothing definitely unfavorable in the heredity.

(c) Environment

In only five cases, or 27.8 per cent, were the surroundings and influence favorable. In four cases both the surroundings and influences were unfavorable. In thirteen cases, or 72.2 per cent, the following factors predominated:

In 5 cases the father was alcoholic;
In 3 cases the father was alcoholic and abusive;
In 1 case both parents were alcoholic;
In 2 cases the father was dead and the mother worked;
In 1 case the father deserted and the mother was insane;
In 1 case the father was dead and the stepfather abusive.

(d) Physical condition

Thirteen of these children, or 72 per cent, were in excellent physical condition. Two had minor defects, and three were in poor physical condition.

(e) Delinquencies

As the trouble of the constitutional psychopathic inferior group lay in the emotional and volitional fields, their conduct was usually an expression of this condition.

Of the eighteen recidivists, ten had one previous court record, five had two previous court records, and two had more than five court records. Their latest delinquencies were as follows:

General incorrigibility........	11 cases
Stealing.....................	6 "
Arson.......................	1 case

Their total offenses were as follows:

General incorrigibility........	27 instances
Larceny.....................	7 "
Burglary....................	6 "
Stealing.....................	7 "
Truancy.....................	2 "
Assault......................	5 "
Arson.......................	2 "

Of the fifty-four offenses committed by these eighteen individuals twenty-seven, or 50 per cent, were for general incorrigibility. This term is used to express such delinquencies as staying away from home, insubordination to parents, small thefts, occasional truancy. The group of constitutional psychopathic inferiors comprises those individuals who are unsuccessful in the environment in which they are placed and whose delinquencies, while not often serious, are usually frequently repeated and finally cause an appearance in court. In two cases the children had been brought to court six times each. One case, a boy of fourteen years, while fairly intelligent, was so unstable that he had been unable to adjust himself in any class at school and had finally been placed in a special class. His delinquencies were as follows—none of them very serious:

Deserted his home
Deserted his home
Stole a baby carriage
Deserted his home
Found with a pair of stolen skates
Truancy
Insubordination in his home
Truancy—committed to truant school
Truancy on release from truant school.

The other case, also a boy of fourteen, had the following record:

Stealing automobile tools
Insubordination in the home
Throwing stones
Throwing stones in a street fight
Striking teacher in school
Truancy.

The homes of both of these boys were not such as to encourage an attempt at readjustment, even with intensive supervision, and both boys were, therefore, placed in an institution.

Psychoneuroses

Of this group there were seventeen—two girls and fifteen boys.

(a) Intelligence

In studying the intelligence of this group, the I. Q. was found to be between .90 and 1.00.

Their school records were as follows:

Grade Reached at School and Age at Time of Examination

Grade	Age						
	9	10	11	12	13	14	15
High School							4
8th grade						2	3
7th "						1	
6th "			1	1		1	
5th "			1	1			
4th "	1		1				

Of these seventeen cases, six were of the psychasthenic type. In these cases there were present phobias, obsessions, and morbid doubts. Ten were anxiety neuroses, consisting of nervous irritability, anxious expectation, and dread. Most of these cases had, in addition, cardiac and circulatory disturbance. One was a neurasthenic who suffered from mental and motor fatigue.

(b) Heredity

The following factors are suggestive in their heredity:
Alcoholism on either the paternal or maternal side in 7 cases
Tuberculosis " " " " " " " 3 cases
Syphilis " " " " " " " 1 case
Insanity " " " " " " " 3 cases

Only in three cases, or 17 per cent, was nothing unfavorable found in the heredity.

(c) Environment

Four cases, or 24 per cent, had good surroundings and good home influence. In thirteen cases, or 76 per cent, the following factors predominated:

In 6 cases the father was alcoholic;
In 1 case both parents were alcoholic;
In 1 case father was alcoholic and the mother neurotic;
In 1 case the father was a criminal and alcoholic and the mother was alcoholic;

In 2 cases the father was a gambler and the mother alcoholic;
In 1 case the father was insane and the mother worked;
In 1 case the mother was immoral.

(d) Physical Condition

In ten cases the children were in excellent condition. In seven cases there were minor physical defects, such as cardio-vascular disturbance with neurological symptoms.

(e) Delinquencies

Of these seventeen cases, twelve had had one previous court record, four had two previous court records, and one had had three previous court records. Their latest delinquencies were as follows:

General incorrigibility........	16 cases
Arson......................	1 case

As in the case of the constitutional psychopathic inferiors, their delinquencies were usually not serious and were generally due to their instability and lack of power to adjust themselves to their environment.

Their total offenses were as follows:

General incorrigibility........	33 instances
Larceny....................	3 “
Arson......................	1 instance
Truancy....................	1 “
Burglary...................	4 instances
Assault....................	1 instance

Psychotic Cases

Of these eight cases there were two of juvenile paralysis, one of traumatic psychosis, and five of undiagnosed psychoses.

(a) Intelligence

In studying the intelligence of this group, the I. Q. was found to be between .95 and 1.10 in the undiagnosed psychoses, and between .80 and .90 in the other cases.

Their school records were as follows:

Grade Reached at School and Age at Time of Examination

Grade	Age								
	7	8	9	10	11	12	13	14	15
High School									2
8th grade									1
7th "									1
6th "									
5th "					1				
4th "			1			1			
Ungraded	1								

(b) Heredity

The following facts are suggestive in their heredity:

Alcoholism on either the paternal or maternal side in 4 cases
Syphilis " " " " " " " " 1 case
Insanity " " " " " " " " 3 cases
Epilepsy " " " " " " " " 1 case

In none of the cases was a favorable heredity found.

(c) Environment

In only one case were the surroundings and home influence good;

In 3 cases the father was alcoholic;
In 2 cases the mother was insane;
In 1 case the father was alcoholic and the mother insane;
In 1 case the mother was syphilitic and immoral.

(d) Physical Condition

The general physical condition of all these cases was poor.

(e) Delinquencies

Of the eight cases, six had one previous arrest and two had two previous arrests. Their latest delinquencies were as follows:

General incorrigibility	7 cases
Stealing	1 case

Their total offenses were as follows:

General incorrigibility	12 instances
Larceny	1 instance
Vagrancy	1 "

Stealing....................	1 instance
In danger of becoming immoral	1 "
Selling newspapers without a license..................	1 "

In these cases the mental condition was so serious that they were early recognized and brought up for examination before their delinquencies had become marked.

Epilepsy

This group was composed of three boys only.

(a) Intelligence

In all of these cases there was some mental deterioration. The intelligence quotient was between .70 and .80.

Their school records were as follows:

Grade Reached at School and Age at Time of Examination

Grade	Age			
	11	12	13	14
High school..........................				
8th grade..........................				
7th "				
6th "				
5th "				1
4th "	1	1		

(b) Heredity

Their heredity was as follows:

Alcoholism on either the paternal or maternal side in	2 cases
Epilepsy " " " " " " " "	1 case
Tuberculosis" " " " " " " "	1 "
Insanity " " " " " " " "	1 "

In none of these cases was the heredity favorable.

(c) Evironment

Their environment was as follows:

In 2 cases the father was alcoholic;

In 1 case both the surroundings and the moral influences were good.

(d) Delinquencies

Each of the three cases had only one previous court record, due, probably, to the fact that epilepsy is easily recognized and that, like the psychotic, epileptics are immediately brought for examination.

Their present offenses were:

Stealing	3 cases

Their total offenses were:

Larceny	4 instances
Burglary	1 instance
Robbery	1 “

Conclusion

It is a well known fact that it is the recidivist who presents the real problem in criminology. The most advantageous place to begin a study of recidivism is in children's courts with preadolescent children.

In studying the 268 cases of recidivists, we discovered, first, that 82.9 per cent of these recidivists, with one previous court record, were mental deviates, and 24.5 per cent of this number were feebleminded; second, that 91.6 per cent of these recidivists, with two previous court records, were mental deviates, and 22.9 per cent of this number were feebleminded; third, that 90.9 per cent of these recidivists, with three or more previous court records, were mental deviates, and 48.5 per cent of this number were feebleminded.

In addition to the fact that mental deviation is found in such a high percentage of recidivists, it is well recognized that many criminal careers are due to the repeated exposure of these individuals to unfavorable environmental conditions. Among the cases brought to the clinic this aspect of the situation was found to stand out unmistakably. Of the recidivists studied, 170, or 63.4 per cent, were found to have an unfavorable environment.

In the light of these facts, constructive work for the prevention of recidivism should be initiated along these lines: changing or improving the environment of first offenders, and recognizing and—as far as possible—segregating mental deviates.

NOTES AND COMMENTS

District of Columbia

A division in the Bureau of Education for the study of the educational needs of mentally handicapped school children is provided for in H. R. 8479, recently introduced in Congress. The work of this division would include the following: "First, the collection, tabulation, interpretation, and publication of the results of tests useful for mental and educational classification, and of information bearing on the organization and conduct of the work undertaken in the schools of this country and elsewhere for feebleminded, backward, and otherwise mentally exceptional children. Second, the conduct of a laboratory of mental tests and standards for the development and standardization of mental tests and standards of mental capacity for normal children of different ages, said tests and standards being essential for the diagnosis and classification of mentally subnormal and abnormal school children and juvenile and adult delinquents. Third, the conduct of a psycho-educational clinic for the examination and classification of mentally defective school children from the District of Columbia or elsewhere." This division of the Bureau of Education would have its own director, to be appointed by the Commissioner of Education, at a salary of $4,500. The bill would provide $30,000 annually for the maintenance of the division.

Iowa

A state psychopathic hospital is authorized by Chapter 235, Laws of 1919. It is to be located at Iowa City in connection with the College of Medicine of the State University of Iowa, and is to be under the control of the State Board of Education. The professor of psychiatry of the college is to be the medical director of the hospital. Provision is made for the admission of both committed and voluntary patients and for their discharge by the medical director when improved or unlikely to be benefited by further treatment. Any patient may be transferred by the medical director to a state hospital for mental diseases when, after a satisfactory period of observation, further treatment at the psychopathic hospital seems inadvisable. The act carries an appropriation of $175,000 for the erection and equipment of the hospital, and the cost of its maintenance is to be borne by the state.

Chapter 366, Laws of 1919, is an act to abolish the State Hospital for Inebriates, at Knoxville. The State Board of Education and Board of Control are to confer together upon the disposition of the hospital and to report at the next session of the legislative assembly what best use may be made of it. The one at Willmar, Minnesota, which was opened in December, 1912, was discontinued by legislative enactment in 1917. The Norfolk (Mass.) State Hospital, which was opened in June, 1914, to receive alcoholics and drug addicts, became U. S. Army General Hospital, No. 34, and has more recently been taken over by the United States Public Health Service for the treatment of epileptics. This leaves the State Farm for Inebriates, at Preston, Connecticut, the only state institution caring exclusively for this class of patients.

The Institution for Feebleminded Children, at Glenwood, has received from the 1919 legislature $35,000 for the construction and equipment of a bakery. The sum of $31,600 has been granted the Independence State Hospital for the completion and equipment of a power house. The State Hospital and Colony for Epileptics, at Woodward, has been granted for new construction the sum of $24,250.

Louisiana

The Milne Home and School for Girls, at New Orleans—an industrial home for feebleminded women—was opened August 18. A department for boys is also contemplated in the near future. The Louisiana Committee on Provision for the Feebleminded last year secured the passage of a law authorizing the commitment of mental defectives to licensed private institutions and making a small initial appropriation for that purpose. Subsequently, a citizen of New Orleans built a school for the feebleminded and put it under the City Poor Department of New Orleans. This department has agreed to begin operation as soon as there are sufficient funds available. In the meantime, feebleminded girls will be cared for at the Milne School.

Massachusetts

The school for the feebleminded at Belchertown, which was authorized by the 1915 legislature, has received an appropriation of $250,000 which will provide for the erection of a storehouse, bakery, laundry, power house, custodial building, dormitory, and road construction.

Nebraska

For additions and improvements at the Nebraska Institution for Feebleminded Youth, $126,000 has been appropriated by the 1919 legislative assembly. The Ingleside Hospital for the Insane received $144,500; the Nebraska Hospital for the Insane, at Lincoln, $14,000; and the Hospital for the Insane of Nebraska, at Norfolk, $127,250 for construction and improvements.

Nevada

The Nevada Hospital for Mental Diseases has received an appropriation of $190,000 for the construction of a new building.

New Jersey

The 1919 legislature has granted an appropriation of $400,000 to the New Jersey State Hospital at Morris Plains for the erection of two "treatment buildings for the prevention and curing of insanity." The State Institution for Feebleminded has received an appropriation of $135,000 for the construction of new buildings. For the purchase of additional farm land the sum of $11,000 has been granted by the legislature to the Village for Epileptics.

New Mexico

The New Mexico Insane Asylum has received from the 1919 legislature the sum of $122,000 for new construction.

New York

The State Commission for Mental Defectives in its report to the governor and the 1919 legislative assembly proposed the state-wide establishment of clinics for the diagnosis and treatment of mental diseases and defects. These clinics would coördinate well with the proposed health centers which the Department of Health is to establish throughout the state. Clinics for mental patients have been maintained by the state hospitals for a number of years and there are at the present time over thirty such clinics. There is need, however, for clinics throughout the state for the mental examination of persons thought to be mentally deficient and plans are now under way for the establishment of these clinics by the State Commission for Mental Defectives.

Plans are being made by the Hospital Development Commission for a state psychopathic hospital in New York City. This hospital will not only provide temporary care for incipient cases of mental disorder, but will be a research department of the state hospitals for scientific study into the causes of mental disease. The plans call for a hospital of 200 beds.

Work has begun on the new state hospital for mental diseases, at Marcy, for the construction of which $2,000,000 has been appropriated. When completed, this hospital will care for 3,000 patients. It will be a division of the Utica State Hospital, from which it is six miles distant. The last hospital for mental diseases erected by New York State was the one at Gowanda in 1898.

North Carolina

The land and buildings of the State Prison and State Hospital for the Dangerous Insane, located at Raleigh, are to be transferred to the State Hospital at Raleigh, in accordance with Chapter 63, Laws of 1919. Patients from the other state hospitals will be removed to this one as soon as the prisoners can be accommodated elsewhere. All negroes cared for at present at the State Hospital for Dangerous Insane will be removed to the State Hospital at Goldsboro as soon as the necessary accommodations can be provided at this hospital for them.

Ohio

Among recent appropriations made by the legislature are $220,000 to the Columbus State Hospital, for five new cottages, $90,000 for the Ohio Hospital for Epileptics, at Gallipolis, and $20,000 each for a hospital for tuberculous patients at the Athens State Hospital and Massillon State Hospital.

Oregon

The sum of $54,000 has been granted the State Institution for the Feebleminded by the 1919 legislature for the construction of two additional dormitories.

Voluntary admission to the state hospitals for mental diseases is authorized by Chapter 125 of the Laws of 1919. According to this law, the superintendent may receive as a patient, for a period not to exceed one month, any person suffering from "nervous diseases threatening mental disorder," upon his written application, provided his mental condition is such as to render him competent to make such application. A patient thus received must not be detained more than thirty days after having given written notice of his desire to leave the hospital. The application may be renewed at the end of one month; but no application shall be effective unless signed in the presence of a friend and also of a medical attendant.

A joint resolution of the last legislative assembly extended to The National Committee for Mental Hygiene an invitation to conduct a survey of the care and treatment of the insane in Oregon. The State Board of Control has been authorized to appoint a committee of three women and three men, who are residents of the state, to coöperate with the National Committee in making the necessary observation and investigation.

Pennsylvania

Four new buildings are to be constructed at the Homeopathic State Hospital, at Allentown, at a cost of over $75,000. The contract for construction has been awarded and will include a home for women nurses, a nurses' dining room, employees' sleeping quarters, and a farmhouse.

South Carolina

The State Training School for Feebleminded, whose establishment was authorized in 1918, has received from the 1919 legislature an additional sum of $57,866.38. The buildings at the school are to be of fireproof construction and are to be erected on the cottage plan.

The State Hospital for the Insane, at Columbia, has been authorized to expend $150,000 for development and repairs.

A resolution was passed by the 1919 legislature to have the laws relating to the state hospital for mental diseases studied thoroughly by a committee composed of a senator, to be appointed by the President of the Senate, and two members of the House of Representatives, to be appointed by the Speaker of the House. It is believed that a complete revision of these laws would be of material benefit to the hospital and its patients. At the next session of the legislature this committee is to make a report and suggest such changes as seem desirable.

South Dakota

The 1919 legislature has appropriated $10,000 to the Home for Feeble-minded, at Redfield, for the purchase of additional land, and $151,000 for new construction and furnishings; $20,000 for improvements to the grounds of the new state hospital for mental diseases at Watertown; $133,000 for new construction and improvements at the Yankton State Hospital, and $125,000 for additional land at this hospital.

Texas

The Northwest Texas Insane Asylum has been granted an appropriation of $350,000 for further construction. This appropriation is in addition to the one made in 1917, when the hospital was authorized. At that time $400,000 was appropriated. Later Wichita Falls offered a free site of 500 acres and free water supply, which offer is estimated to be worth $100,000. This hospital will care for white insane patients, the colored patients being provided for at the hospital at Rusk, authorized in 1917. Texas maintains three other hospitals for mental diseases.

DEPENDABLE STATISTICS ON MENTAL DISEASES

In spite of the fact that the total number of beds in hospitals for mental patients in the United States exceeds the number in general hospitals, very little reliable statistical information is available concerning the prevalence, causes, treatment, and prevention of mental diseases. Reports of hospitals caring for mental patients give many details with reference to administrative and financial problems and much information relative to the farms and gardens and the products of the dairies, piggeries, and henneries. In marked contrast with these illuminating details are the meager data with reference to the patients.

One of the primary causes of this lack of information has been the absence of a well-devised system of recording and classifying observations in hospitals that treat mental patients. Until recently there existed in this country no generally accepted classification of mental diseases nor even a uniform system of recording data concerning admissions, recoveries, and deaths of patients. Classifications used in some states were similar in many respects, but differed just enough to prevent their use for cumulative or comparative purposes.

Realizing the need of a standard nomenclature of mental diseases and a uniform statistical system for the use of hospitals for the insane, the American Medico-Psychological Association, at its annual meeting in June, 1913, appointed a committee to consider this matter and to devise ways and means for improvement. This committee held several conferences, consulted experts, appointed subcommittees to consider various phases of the work, and gave the whole matter very careful study. Its first efforts were directed toward the preparation of a classification of mental diseases that would meet the demands of modern psychiatry and at the same time be acceptable to the hospitals for mental diseases in this country.

After the final report of this committee—which set forth the need of better statistics of mental diseases and recommended a nomenclature and statistical system—was submitted to the Association in May, 1917, and unanimously adopted, a standing Committee on Statistics was appointed to promote the introduction of the system throughout the country. This committee invited The National Committee for Mental Hygiene to coöperate in the work.

With an appropriation from the Rockefeller Foundation for the purpose, the National Committee, through its Bureau of Statistics, began work in this special field in February, 1918. The first step consisted in submitting the classification and the outline of the statistical system to the superintendents of state hospitals for mental diseases. Later a manual was prepared containing definitions and explanations of the terms used in the classification, suggestions for the diagnosis of the various clinical groups, and directions for the preparation of annual statistics. This manual and a series of eighteen standard statistical forms were supplied without charge to all coöperating hospitals. Within a year, 145 of the 156 state hospitals in this country, together with a number of city, county, and private hospitals that care for mental diseases, have signified their willingness to follow the new classification. These comprise all the state hospitals in forty states, and some in all but three of the others. The new system has also been adopted by the federal hospital for the insane and by the Division of Neurology and Psychiatry in the office of the Surgeon General of the United States Army. Published reports containing data prepared according to the uniform system are being received and show a marked improvement over those issued in previous years. Very recently the American Association for the Study of the Feebleminded has appointed a Committee on Uniform Statistics to coöperate with the Committee of the American Medico-Psychological Association and The National Committee for Mental Hygiene. It is practically certain that the fifty state institutions for the mentally defective and the epileptic will soon be added to those employing the forms adopted.

In order to promote efficiency in the statistical work of the various institutions, standard sets of record cards have been prepared and distributed at cost to all hospitals requesting them. These cards, when properly filled in, contain all the information called for on the tabular forms and facilitate the compilation of annual statistics. At the present time, they are being used in over fifty hospitals, and more than 50,000 cards have thus been distributed.

The Bureau of Statistics of The National Committee for Mental Hygiene is now engaged in the preparation of a review which is planned to give a summary of general information, financial operation, and movement of population of the various state hospitals in the country. Since many of the hospitals did not begin to use the classification until late in 1918, the preparation of a statistical review with complete reports from state hospitals will have to be deferred for a time.

In attacking any problem, it is first essential to know its size. The adoption of the new classification and uniform statistical system will make it possible to obtain information concerning the prevalence of the various types of mental disease in hospitals throughout this country. Further, accurate data will also be possible with reference to the causes of insanity, the frequency of its different forms, relation of sex, age, race, occupation, and climate to the several psychoses, duration of hospital residence, recovery and death rates, etc., through careful study of the annual statistics prepared by the hospitals in accordance with the standard uniform system. The fact that on January 1, 1918, there were 239,820 patients in public and private hospitals for the care of the insane in the United States* is sufficient proof that there is no lack of material for such studies. In addition to the great amount of information unquestionably needed that may be thus secured, the adoption of this classification of psychoses throughout the United States will do more toward promoting the standards of scientific accuracy in the field of mental medicine than anything heretofore attempted or even proposed.

WAR NEUROSIS IN THE BATTLE OF MARATHON

"Is this, perchance, the first account of 'shell-shock'?" queries Dean A. Worcester in a recent letter to the editor of *Science*. Dr. Worcester quotes Herodotus, describing the battle of Marathon, 490 B.C. (Book VI., section 117):

"The following prodigy occurred there: an Athenian, Epizelus, son of Cuphagoras, while fighting in the medley, and behaving valiantly, was deprived of sight, though wounded in no part of his body, nor struck from a distance; and he continued to be blind from that time for the remainder of his life. I have heard that he used to give the following account of his loss. He thought that a large heavy-armed man stood before him, whose beard shaded the whole of his shield; that this specter passed by him, and killed the man that stood by his side. Such is the account I have been informed Epizelus used to give."

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* Annual Census of the Insane, Feebleminded, Epileptics and Inebriates in Institutions in the United States, January 1, 1918. By Horatio M. Pollock, Ph.D., and Edith M. Furbush, A.B., B.S. MENTAL HYGIENE, 2:78–107, January, 1919.

HARRISBURG MENTAL HYGIENE CLINIC

In November, 1918, the Mental Hygiene Committee of the Public Charities Association of Pennsylvania organized a mental hygiene clinic at Harrisburg under the general direction of Dr. W. E. Wright, formerly a member of the staff of the Harrisburg State Hospital. A preliminary report of the first few months' work of the clinic shows most interestingly not only the need for such a clinic in the vicinity in which it is established, but the extent to which neighboring communities reach to it for assistance. While the majority of patients attending the clinic came from Harrisburg, patients were brought, also, from sixteen cities and towns in the vicinity.

PSYCHOLOGICAL CLINIC IN LOUISVILLE, KENTUCKY

In Louisville, Kentucky, there has been established a psychological clinic which stresses the intimate relation between organized social service and mental hygiene. This clinic is under the joint control of the board of education and the Louisville Welfare League. Under the latter orgainzation are federated the social agencies of Louisville. These agencies refer cases in which mental trouble is suspected to the clinic for examination. In addition the clinic is at the service of the juvenile and police courts of Louisville. In the latter, as a matter of routine, the clinic is examining all infected women quarantined by the venereal clinic.

Surveys are being made of the various institutions, such as the orphanages, reformatories, etc., to identify mental defect among the inmates.

The importance of determining the presence of mental defectives and psychopaths among the inmates of child-placement institutions needs no emphasis. Defective children should not be recommended to homes where they will be given care and training of which a normal child might take advantage. The Louisville clinic examines all the admissions to the Kentucky Children's Home Society.

In the public schools, special classes for superior children—called "opportunity classes"—and atypical classes for mentally retarded and defective children have already been established. The staff of the clinic examines candidates for these classes.

Group tests of mentality have made possible the testing of large numbers of individuals at one time. A mental survey of the Louisville schools is projected under the direction of the clinic staff.

Henrietta V. Race, Psychologist of the Louisville Public Schools, is director of the clinic. Frank S. Fearing, recently in charge of the psychological examinations in the Psychiatric Division at the U. S. Naval Training Station, Hampton Roads, Va., is the assistant director. Associated with the clinic are two psychiatrists, Dr. W. E. Gardner and Dr. H. B. Scott. They are on the staff of the Louisville City Hospital, and thus are able to place the psychopathic ward of that institution at the service of the clinic.

MISSISSIPPI SOCIETY FOR MENTAL HYGIENE

A meeting was held in the rooms of the Jackson Board of Trade, Jackson, Mississippi, August 15, 1919, for the purpose of organizing the Mississippi Society for Mental Hygiene. Dr. C. D. Mitchell, Superintendent of the Mississippi State Insane Hospital, was elected temporary chairman, and Dr. J. H. Fox to serve as secretary. The following resolutions were passed:

That it is the sense of this meeting that a State Society for Mental Hygiene, to be affiliated with The National Committee for Mental Hygiene, shall be organized in Mississippi, and that it shall be known as the Mississippi Society for Mental Hygiene.

That the chairman of this meeting shall appoint a temporary organising committee of not fewer than seven or more than fifteen members, which shall have power to adopt a constitution and by-laws, and appoint not more than two-thirds of the members of the original board of directors, who, upon call of the temporary organizing committee, shall meet and perfect the organizing of the Mississippi Society for Mental Hygiene by formally adopting the constitution and set of by-laws and by electing such officers, et al., as may be provided for in the by-laws.

That this temporary organizing committee shall have power to take any other action for the society which it shall deem expedient.

It is proposed to have a larger meeting and effect permanent organization in October, when the Mississippi State Fair will be held in Jackson and there will be a state meeting of the American Legion.

Those who attended the organization meeting were: John L. Green, Superintendent, Mississippi Children's Home Society, Jackson, Mississippi; J. H. Fox, M.D., formerly Assistant Superintendent, Mississippi State Insane Hospital, now in private practice, Century Building, Jackson, Mississippi; C. D. Mitchell, M.D., Superintendent, Mississippi State Insane Hospital, Jackson, Mississippi; Mrs. Arthur Granberry, Member of the Mississippi Mental Hygiene Commission; Herschel Brickell, Associate Editor of the *Jackson Daily News;* Kate Markham Power, formerly of the *Jackson Daily News*, and lately W. C. C. S. Representative at Camp Sheridan, Montgomery, Alabama; Marcia Gibbs, Principal, Poindexter School, Jackson, Mississippi; J. R. Carter, Superintendent, Baptist Orphanage, Jackson, Mississippi; and Thomas H. Haines, M.D., Scientific Adviser to the Mississippi Mental Hygiene Commission.

THE WEEK'S MEETING ON CRIMINAL LAW

Editorial, *The Boston Herald*

The people of Massachusetts are probably as peaceable as those of most states, yet it is necessary to have seventy-five courts to settle our controversies. Some of these are between citizens, over matters of business. The state is intolerant of these. It has created tribunals to adjust them, and it compels the parties to accept their decisions. There are also controversies between the state and its own citizens. Well-nigh 200,000 of them break its laws every year. The state settles these controversies, also, and compels the adverse party to accept its decision.

Most of the state agencies which deal with social problems have the future in view, in their work, but the courts are peculiar in this—that on the "civil" side they deal with past transactions, and on the criminal side with past actions. In settling business controversies the state takes action in order that business may go on. In disposing of criminal cases its aim is to prevent lawlessness by compelling the offenders to accept its standards. In this it succeeds only partially.

Within a few years the courts have changed their views and purposes radically. They have come to see that little has been accomplished, and that little can be accomplished, under a system which deals only with the past of a wrongdoer. To find, on the evidence, that on a certain day a man violated a law of the state, and to impose a penalty for that past act, "making it fit the crime," leaving the offender with an unchanged purpose, ready to commit another crime, was a waste of a large part of the effort expended.

The changes in the methods of modern courts for criminal business have been made with the purpose of centering the attention of the offender on his future, rather than on his past. To do this the state sets an example, by considering the crime mainly as an indication of the character of the criminal, and of the treatment needed to readjust him in society as a good citizen. They aim to make this treatment fit the individual criminal, rather than his crime, which necessitates new methods, new machinery, and a new spirit.

The men who, ten years ago, formed the American Institute of Criminal Law and Criminology, which will hold its eleventh annual meeting in this city this week, beginning on Tuesday next, saw that these changes in the direction of the efforts of the criminal courts, if they were to be made wisely, must be accomplished by the coöperation of many intelligent, progressive, well-balanced men. The declared object of the institute is "to further the scientific study of crime, criminal law and procedure; to formulate and promote measures for solving the problems connected therewith, and to coördinate the effort of individuals and of organizations interested in the administration of certain and speedy justice."

SOMETIMES

You can't educate a grasshopper. He's too busy hopping. The peculiarity of man is that sometimes you can induce him to stop and think.—Samuel McChord Crothers, *Atlantic Monthly*, September.

The Scandal of Euclid: A Freudian Analysis, by Simeon Strunsky, in the *Atlantic Monthly* for September, which purports to be a review of a book, *Sex Elements in the First Five Books of Euclid*, will be of interest to students of pyschoanalysis.

APPEALING TO BRAINS DISEASED

Editorial, *The New York Herald*

Institutional and public correctional authorities having to do with delinquent children have not been satisfied entirely with the result of the approved methods for the education of their charges even when those methods have been thoroughly understood and conscientiously followed. Prior to 1825 all juvenile offenders of both sexes were housed and cared for along with adult criminals. Those schools of iniquity long ago gave way to separate institutions for boys and girls, from which the country has greatly benefited, but which, it seems, are not yet conducted on a system from which the best results may be obtained. Too often the outcome is antisocial reaction in adolescence, to end in careers of crime or worthlessness.

Recent studies by the United States Public Health Service of the mental condition of the inmates of private and state schools for such children have shown that a far greater number of the inmates than is generally supposed to be the case—about 11 per cent—are under average mental development or suffer from some form of psychic disturbance. Little difference is observed between such children and those of more normal mind in the grouping for class work. The present training system does not recognize the need of it. Dr. W. L. Treadway in a report holds that it is impossible to reform these afflicted little ones because they cannot respond to such efforts. He urges special and individual care in such cases.

This problem is one that should be given serious attention. Public Health Service officials strongly urge that a psychopathologist be placed on the staff of every correctional institution and made a part of every juvenile court. They argue these measures would tend to a better understanding of the psychopathic child, insure a more promising grouping of delinquents, and assure the proper disposition of particular cases. The conclusion of the investigating medical officer is that mental disorders must be taken into account in trying to reform youthful prisoners committed to beneficent institutions rather than to jail.

ORDINANCES FOR THE CONTROL OF VENEREAL DISEASE

For the benefit of cities that wish to enact legislation looking toward the control of venereal diseases, the United States Public Health Service, aided by the Law Enforcement Division of the War Department, has prepared a compilation of ordinances that have been found successful in the campaign against these diseases. Among them are ordinances dealing with the licensing of hotels, rooming houses, dance halls, and public vehicles, and with the regulation of restaurants, etc., and prohibiting the advertisement of venereal disease "cures" or the sale of venereal disease medicines except on prescription. Each of these ordinances has been put into effect in various cities with satisfactory results. Cities that wish to adopt similar legislation are advised to consult competent legal authority as to the changes necessary to meet constitutional and charter requirements.

The index for Volume III of MENTAL HYGIENE will soon be ready. Subscribers who wish a copy of this index will be supplied with it upon written request.

ABSTRACTS

THE WAR NEUROSES AS PHYSIOLOGIC CONSERVATIONS. By SIDNEY I. SCHWAB, M.D. *Archives of Neurology and Psychiatry*, 1: 579–635, May, 1919.

The problem presented by the war neuroses to the A. E. F. was in one respect essentially different from that with which any of the allied armies had to deal. Both the French and the British were comparatively near their home bases and could utilize for patients suffering from war neuroses practically all the medical resources of their respective nations. For the A. E. F. transportation difficulties made this impossible; they had to handle such cases on foreign soil at or near the actual zone of fighting. In consequence, while they were able to take advantage in many ways of the experiences of other nations, they had to evolve a system of treatment adapted to their own peculiar circumstances. The result, briefly put, was the system centering around Base Hospital 117 at LaFauche, of which Dr. Schwab, the author of the present article, was medical director. And a further result—and one more important in its bearing on peacetime problems—was the development of what Dr. Schwab calls "the A. E. F. point of view." It is this point of view that Dr. Schwab is particularly interested in explaining, with the idea of its applicability "to the same kind of problems, less dramatized perhaps, which have been so common in times of peace."

The A. E. F. point of view was largely determined by the conception of the war neuroses held by Colonel Salmon—the senior consultant in neuropsychiatry—and some of the chiefs of departments under him. The war neuroses, in their opinion, were an aspect of a primitive defense mechanism designed to protect the human organism against the injurious or unpleasant incidents of warfare—a defense mechanism that "inserted itself automatically between the soldier and a repetition of the same or similar incidents which in the first place caused the soldier to react as a war-neurosis case. As a result of this view, formulated early enough to make it a part of the general scheme of treatment and organization, war neuroses were recognized as very real conditions, one to which any soldier, given a succession of etiologic incidents, might fall a victim. In this way, also, the soldier could be viewed objectively and dispassionately in relation to his neurosis and the same method could be followed as is in vogue in the study of the many types of infections and other diseases to which a soldier in the performance of his duty is subject.

"The question of the soldier's participation in the formation of his neurosis, how much conscious effort went into it, the rôle of exaggeration and malingering and other confusing incidents, might then be made the object of legitimate inquiry, uninfluenced by preconceived notions in respect to courage, bravery, wish, desire, cowardice, etc."

The problem of the war neuroses has three main aspects. In the first place, there is the military. "This concerns itself with the important fact that the soldier with war neurosis is, in most instances, physically intact and very often in splendid physical condition. . . . He obviously cannot be classified as mentally unfit, nor can he be regarded as physically disabled, yet he is incapable in this state of acting the part of a soldier. The fact that he has, at times, only a limited power of volition over his disability removes him from the class of malingerers, so the aspect of a man neither sick nor well presents a military problem of an unusual sort. As many of these patients have been good soldiers, judgment as to their potential ability for further military life must be suspended. Where to place him and what to do with him are questions that present themselves immediately. A soldier physically fit, mentally not affected, in every outward aspect a good fighting type, not a coward, often wanting to get back to the line, but held in the grip of a mechanism which negatives his soldierly impulses, presents a problem that has mystified again and again an officer who has at heart the best interests of the men under his command. Where the number of such cases increases to such an extent as to threaten seriously man power, then more than ever do the war neuroses assume the dignity of military importance. Therefore, no statement of the problem of the war neuroses can be made without considering from the very beginning its military significance. Many of the errors made in attempting to solve the problems of the war neuroses among soldiers might have been avoided if at all times the military point of view had been kept in mind. This point of view might be expressed as the effort toward returning such a patient to his former status as a soldier, with the assumption that this is a perfectly possible thing to accomplish."

The second aspect is the clinical; this has to do with the symptoms or appearances presented by the neuroses—their classification into types and the devising of adequate methods of handling them.

The third is concerned with the mechanism of the neuroses, the obscure processes which underlie the symptoms and produce them, and which must be understood before treatment can be intelligently administered.

There are other aspects of the problem which have forced themselves into it, as it were, often complicating it most unfortunately. For example, there is the question of responsibility on the part of the patient—whether he is not morally weak and lacking in courage. The difficulty with such questions is that they do no good to the patient and interfere with the consideration of his case as a medical problem. "Strangely enough, many physicians in contact with these cases spent more time and energy in trying to decide whether the soldier, a victim of war neurosis, was worth bothering with at all than in attempting to appreciate what it was that had happened to him. A possible explanation of this curious attitude might perhaps be found by subjecting those physicians themselves who held such curious unmedical views to processes of analysis used in studying the war-neurosis soldier. It was, in a sense, the evidence of an unconscious overactivated fear that they themselves, under proper conditions, might very well develop all the symptoms against which they showed so unsympathetic and uninformed an attitude. The proof of this statement may be found in the fact that men who have been through the actual experiences of front-line work learn to view the victims of war neuroses with a new understanding and insight. It is this tendency of defense by the exaggeration of a normal repulsion to evident weakness in another that establishes what seems to be one of the most fundamental facts in the war neuroses themselves—that is, a defensive purpose as part of the great system of physiologic conservation. There is found in presumably normal men, in this instance physicians, evidence of a mechanism of this kind, focusing on an anticipated set of experiences. The identical mechanism must necessarily be put into action when the experiences are no longer merely anticipated, but real.

"The conception of the war neuroses as a defensive mechanism or as a part of a system of physiologic conservation may be approached with less difficulty if it is made clear just what is implied by those terms. It is necessary also to appreciate the fact that the defense meant here is not conscious, but automatic and probably altogether outside of volition. There exist in all living organisms sets of factors which work toward the saving of those organisms from destruction. There exists likewise in each important function of that organism a mechanism for preventing function from becoming excessive and preventing injury to it as a whole or to its respective elements. Living would be impossible if this did not exist. The protection may be purely automatic and adjustable to mechanical factors, as for instance the hypertrophy of the heart; it may be chemical as in the immunity defense, or it may be various combinations and mixtures in which polyglandular activities come into play; it may be physiologic in respect to functional adjustments and psychical when deeper and more intricate activities of consciousness are at work. The latter may be termed physiologic, but for convenience it is better to consider it a definite psychogenic mechanism.

"This principle of organic defense appears to be a very fundamental thing, touching on the very innermost principles of living things. Naturally this principle has long been recognized and, by whatever term it has been designated, it has been an admitted fact to be considered always in the attempts to understand the phenomena of life. When the mechanism of defense, whatever its nature is, becomes inactive or less efficient, the living organism may be said to approach destruction, or if it fails completely the organism dies. It is possible, perhaps, to divide the defense mechanism into two classes, one acting to prevent the mechanical using up of living tissue—the wear and tear of the machinery of life, as it were—the other to resist and modify the exogenous factors of a destructive kind to which every living thing is ceaselessly exposed. It is obvious that even if no sharp line of demarkation can be said to separate these two, yet the adjustability of the defense shows, in either instance, a difference in the quality of promptness and speed with which it can be put into action. The mechanically incited defensive organization is apt to be slow and cumbersome, taking place gradually according to the progress which the changed conditions of the mechanism itself necessitates, while the other must be capable of meeting quickly and decisively the immediacy of an oncoming event. Therefore, the latter type of defense must possess a certain power of selectability or adaptability because events or experiences are in their very nature dissimilar and varied. This seems to be true of the neuroses in general, and of the war neuroses in particular. If they are studied from such point of view as this, they show the characteristics of an exquisitely adjustable and often complicated piece of psychical machinery, adequately and, in a sense, personally fulfilling the purpose of protecting the individual against reëxperiencing a series of destructive events to which he has been recently exposed. The analogy between the organically inspired defense mechanism and those physiologically activated or sensitized, as some one has described them, probably goes no further than this, and the comparison has served its purpose if the fact has been made clear that the neuroses, defensively considered, are a part of a mechanism so fundamental for the preservation of life, as a physical phenomenon, that their existence cannot well be doubted. There is nothing new in this conception. Freud long ago, and others before him, had seen in the neuroses something more than a collection of symptoms simulating organic diseases. Many students of the neuroses have been impressed with the apparently needless overemphasis of symptoms in face of slight degrees of possible determining factors, and they must have seen in this, or dimly felt at any rate, that some other incentive was at work than merely processes of reaction on the part of the organism. It was in this zone of overresponse that the explanation was to be found."

This defense function of the neuroses is what fundamentally distinguishes them from the psychoses. During the early part of the war, French and British physicians were inclined to regard them as mental diseases, and the question whether they are or are not psychoses is one that inevitably arises in the mind of any one who has to do with large numbers of soldiers suffering from them. "Clinically, they are often similar to well-recognized and conventional types of psychoses. Unlike them, however, they show a surprising quality of getting rapidly and unexpectedly well." What, then, is the essential difference between the two?

"As a preliminary point the psychoses which are here touched on are the so-called inorganic types. None of those due to organic changes, or defects in the brain, or to the results of toxic or chemical processes, are considered. This is not an arbitrary distinction, but one made necessary by the assumption which has been so often emphasized that the neuroses are defensive mechanisms, demanding always as their first requisites a consciousness that can act in a normal manner.

"The difference, then, between the psychoses so limited and the neuroses lies largely in the notion that in the psychoses there is a want of a primary and logical purpose. A psychosis in the long run always acts to the disadvantage of the individual, both in relation to his immediate environment and to society. Its origin, therefore, must lie in processes of consciousness which are permanently abnormal, destructive, and constantly departing from a normally acting intelligence. Sooner or later a psychosis brings the individual in conflict with himself, his class, and society.

"The neuroses, on the other hand, never do this, nor can they do it. For as their origin and purpose are fundamentally protective, a conflict leads to the enfeeblement and eventual disappearance of the individual out of his environment. The neuroses are, therefore, protective mechanisms which tend to guard the individual from the immediate event for which he lacks proper personal adaption. The psychoses, on the other hand, serve no protective purpose whether immediate or remote, but on the contrary tend logically to the destruction of the individual in the conflict of events. They are permanent deviations, progressive in type, which arise without set purpose, and are the consequences of abnormal processes in consciousness. They tend to the elimination, not the saving, of the individual. In the struggle with society it is generally the individual who succumbs, either as a living organism or as a member of a social order. The neuroses, on the other hand, are the products of an intelligence awake to the needs of the individual and are structures of compromise between him and society. They tend to shield him and so do harm to society. They arise in consciousness from fully realizable premises, but tend to become automatic and without the individual's awareness, so that he reacts to them instead of the things that he is cognizant of in his own make-up.

"It is to be noticed that in this definition of the neuroses there is no attempt to fix on an etiology. The causative factor of events is touched on, but it is given no specific meaning. In the war neuroses, on the other hand, there is the qualifiying factor of war, and this definition, to have any value for the present purpose, must hook up with the ever-present set of circumstances associated with military activity in war time. This brings with it an important element scarcely hitherto touched on in this paper, and that is the instinct of self-preservation and its activating source—the emotion of fear.

"No attempt will be made here to define instinct. Two of the instincts may be called primary, primitive, or fundamental. These two are the instincts of self-preservation and propagation. They represent certain necessary qualities of life without which life would be impossible. That is, it could not continue. To be continuous it is essential that the individual should live at least long enough to propagate, in this way preserving the quality of continuity. Neither of these two qualities is possible without some mechanism tending in the long run to preserve life as existent, and to prolong it beyond its individual expression. These two instincts might be termed essential because they are necessary parts of the phenomenon of living.

"In the other instincts, and their number is as great or as little as is preferred, it is found that they do not represent these innate and essential qualities, but do represent certain tendencies or impulses which depend rather on racial or species experiences. These are the things that have in the long run acquired a certain positive value in the struggle both to prolong the life of the individual and to render as easy as possible the passing on of life beyond the individual. Such tendencies are probably acquired and inheritable. By repetition from one series of individuals to another they become dominant. The nervous mechanism by which they are set in action becomes by each successive wave of individuals more adapted and prepared for the reception of the sensory excitant, the emotional background, and the motor outlet. In some such way they tend to develop into complicated reflexes, each one of them conditioned by a particular set of circumstances.

"In the war there is the essential instinct of self-preservation. This is the instinct primarily involved. Many of the others play their part, but are secondary and unessential. In the war neuroses the motive is furnished by the presence—in a very active and, to the individual, unusual way—of the instinct of self-preservation. The war neuroses may be looked at, then, as an elaboration of this instinct carried out, as primary instincts always are, without the individual's will or knowledge. They are defensive, automatic adaptations on this basis because the individual has no longer the power of adapting himself to immediate condition and he surrenders himself to a more powerful defense than he himself can possibly, consciously, construct."

A question that has been much discussed in connection with the war neuroses is that of what has been called neuropathic inheritance tendency.

"The reasoning ran something like this. No soldier who is not of a neuropathic type can develop war neurosis. The fact that he shows symptoms of this condition is an admitted proof that he belongs to this class. Thus, having arrived at this conclusion, all that remained was to find evidence supporting this contention from the patient's past history or the stock from which he came. In a very high percentage of cases sufficient data of this kind could be found. This was taken as proof of the contention."

But a study of the personal histories of large numbers of soldiers, both those who were suffering from war neuroses and those who were not, seemed to show that neuropathic inheritance tendencies played a very small part in the production of the neuroses.

"Fear and fear reactions certainly cannot be set down as neuropathic traits, and as they are the most important energizing factors in the etiologic sequences of war neuroses, it follows that any soldier, neuropathic or not, may be viewed as a potential case of war neurosis. This, after all, seems to be the most illuminating point of view and by far the most useful, and as such it fits in with the conception advanced in this paper. As a possible predetermining influence in the series of incidents leading to the development of war neuroses in a soldier, neuropathic inheritance has some importance, but an importance completely overshadowed by the more active set of traumatically converging incidents which will now be described.

"In order that the mechanism of automatic defense may be set to work, the average soldier must undergo a series of events which tend to weaken what may be roughly and rather inexactly termed his ordinary self-control. By this is meant that he must be put temporarily in a condition where his normal mechanism of inhibition is seriously weakened. By inhibition in this sense is meant the totality of his power to control the natural exhibition of the phenomena of fear, terror, nervousness, horror, etc. To this must be added the positive factor which strengthens the inhibitory impulses—that military quality which keeps alive and ever present in consciousness the recently acquired traditions and customs of a soldier. This is an element of morale. The mental process by which this is accomplished is suppression or repression. Inhibition is merely a larger and more physiologic way of expressing it.

"The important set of circumstances which tend to weaken this faculty are: (1) exhaustion; (2) fatigue—the more chronic phase of exhaustion; and then in succession sleeplessness, lack of food or water, worry, responsibility and incidents of a particular, horrifying or unaccustomed kind, loneliness, strangeness, ill-treatment, etc. The list of these incidents might be endlessly multiplied, but enough has been set down to indicate their character. The importance of incidents like those that have been mentioned and others of a similar kind lies in the fact that they tend, each of them or in combination, to weaken the individual and to prepare the way for the reception of the final traumatic incident. They create in the soldier, so to speak, a favoring terrain; they further tend to develop in him a soil of receptivity, in which or on which the neuroses, given the proper setting, can easily develop, become fixed and chronic. In opposition to these, the soldier, according to his peculiar personal make-up, struggles either forcibly or feebly according to the measure to which he has surrendered himself to his career as a soldier. Back of all this lies no doubt many an emotionally-tinged impulse, leading straight back to his former nonmilitary existence. Among these may be mentioned the mass effects of discipline, or morale, the grip of idealism which led him to offer himself as a fighter, his experience with the German as an antagonist, the memory of slaughtered friends or comrades, his love for his officers, the honor and reputation of his regiment, and things of that sort; all of them or some of them are present in the make-up of every soldier. They form the counterflow against the on-rush of factors which center about the condition called fatigue or exhaustion. It is to be noted that in whatever stage of fatigue the soldier now happens to be, he is still in possession of consciousness and a knowledge of himself. In no way has he departed from the condition of a consciously controlled human being. No matter how feebly the inhibitory impulse is asserting itself, it is still to some degree active, and to that extent the soldier is aware of himself as a soldier, perfectly responsible and responsive to the demands of his position. It may be argued that, in the extreme stages of fatigue, the condition of automatism may be reached, but even if this were so, its approach is too gradual to permit the neurosis structure, instinctively fortified by the necessity of self-preservation, to take complete hold of him. At this stage there comes into play a very important and significant psychologic element in fatigue. This is a very unusual and possibly suddenly developed state of suggestibility. This extraordinary state of receptivity, not only to outside things, but also to ideas, memories, and emotions of endogenous origin, forms, perhaps, the most favoring circumstance for the development of the neurosis which at this moment is awaiting an opportunity to enmesh the individual in its defensive system.

"From this point on, two sets of things may happen. Both of them have a precipitating effect and both tend to act in a positive and dynamic fashion equally effective in the production of the first and necessary phase of a war neurosis. One set of incidents has to do, in a certain proportion of cases, with the purely mechanical results of a shell explosion in the immediate neighborhood of the soldier, by which he is shocked to a greater or less degree, so that there is momentary loss of consciousness, or it may extend over some hours, as the case may be. As a rule, he either falls or is thrown to the ground, or wanders about in a confused way, and immediately enters into a state in which conscious inhibition is for the time being totally in abeyance. The other set of incidents has to do, not with a mechanically working factor, but with the appearance on the scene of some sudden, unusual, or terrifying experience which, emotionally overloaded, tends to produce exactly the same condition."

Frequently, though not always, this experience is a shell explosion and the resulting concussion.

"Whatever the immediate factor may be, a period of unconsciousness, confusion or a dazed condition appears to be one of the most significant and almost necessary preliminary states favoring the development of a neurosis. Such a condition offers to the protective mechanism the opportunity to work, unaffected by the ordinary control of the touch with reality, which is implied when consciousness remains undisturbed. That a neurosis can develop without an intermediary state is of course true, but in these instances the mechanism at work is of a much slower and more complicated kind, leading to approximately the identical condition through endogenous processes largely activated by emotional hyperreactions, breaking through consciously acting repression.

"Looking at the thing as a process, and nothing else, there is evidently a state reached by the soldier going into a neurosis when, for the time being, his conscious control is weakened or lost, and at that period the instinctive reactions take possession of him, and uncontrolled by anything that he can at that moment interpose to counteract them, open the way for the self-preservation instinct to obtain its fullest influence. At any rate, he remains under its control until one of two things happens. One leads back directly to the restoration of himself in his soldier capacity, in which instance no neurosis develops; the other, further and further away from his normal soldier self into something totally unlike and alien to the thing that he was, and then he begins to show one of the many types of the war neurosis.

"In the course of this process another important element in the mechanism comes into play, especially during the period of transportation to a hospital and in the early days of the soldier's stay there. The process by which the initial symptoms become either temporarily fixed or tend to further elaboration has been described by various terms. None of them are, however, very satisfying. What happens is that there is given an opportunity for more complete concentration and introspection, so that the individual, removed from contact with his accustomed environment and away from the external influences of camp, line and military discipline, easily surrenders himself to his neurosis, which automatically tends to further elaboration and intensification of symptoms. If this is not counteracted by skillfully planned medical intervention, intensive, and above all promptly put into effect, the war-neurosis subject falls under the complete sway of his neurosis and the picture becomes completely that of a well-developed and chronic type. That there is more at work in this stage than pure automatism and unconscious impulses must be admitted. That there gradually develops a fairly active desire not to get well, but to remain in the apparently safe grip of the neurosis instead of facing a return to conditions which led to its production seems also evident. There is also here seen the beginnings of another process—that is, a struggle between the innate desire to return as a soldier and the automatic persistence of the preservative tendency previously alluded to. Cases left untreated, neglected, or contemptuously handled rapidly develop into this state, and as a result form the most difficult subjects for subsequent treatment.

"There is a group of cases to which much that has been described above does not apply. It is mentioned here because it occurs in a condition very largely met with in the officer class and which may or may not have as an etiologic factor the acute traumatic incidents seen so frequently in the soldier types. The anxiety neurosis has a mechanism which is more complicated and in which the defensive element is obscured by the presence of an intense and persistent conflict. This conflict has its origin in the necessity, which an officer at all times is conscious of, to conceal from the men under him and from himself, too, every evidence of emotional stress he may be passing through. This he does by the use of repression. The repressed material of his experiences, notably those in which emotional loading is strongly present, activate the conflict between his desire to maintain and follow the tradition and training of an officer and the strongly entrenched but completely unacknowledged instinct to save himself. The essential difference between his reaction to the sequence of traumatizing events, just described, and that existing in the case of the soldier, lies chiefly in the fact that there is an ethical element at work which intensifies the conflict and causes him, in many instances, a great degree of mental distress, suffering and self-accusation. This produces the state of anxiousness which is often the only and sometimes the chief evidence, externally at least, of his neurosis. . . .

"The anxiety type of neurosis presents a much more highly developed, pure psychologic defense than the other forms. Its relation to physical factors is often much more difficult to demonstrate. In fact, it is often found developing after a rather long sequence of psychically acting traumas showing markedly insidious progress and evidently originating from insignificant and not easily demonstrable beginnings. Its defensive character is chiefly in the fact that it renders an officer incapable of positive action, reducing him to a state of neutrality. In this condition he becomes, one might almost say, the prisoner of his conflict, and remains inert, without energy, without initiative, controlled almost wholly by the emotional stress engendered by the conflict going on within him. He is frequently unaware that such a conflict is present, the repressing mechanism working automatically to keep out of his waking consciousness all evidence of a thing of this sort. What he is aware of, and that very acutely, is his own mental distress and the physical expression of the emotional strain he is under. These external signs of fear, worry, etc., are dissociated in his own consciousness from the sources to which they owe their origin, and he is thus as much a puzzle and mystery to himself as he is often to the neurologist under whose care he may happen to be.

"Several bits of qualification must be added to much of what has been written in this attempt to state the clinical problem of the neuroses from the point of view of its underlying mechanisms. It is necessary to appreciate the fact that in trying to trace the sequence of happenings which a soldier passes through on his way to a neurosis, an average of such experiences was recorded, something that might be accepted as a plan of a physiologic experiment if the soldier could be made into a laboratory problem. There is no thought of making this entirely applicable to every case of war neuroses, or, in fact, is it certain that any one ever passes through just the things that were described. Of all things in the world the war neurosis lends itself least to dogmatic statements, but what has been set down appears to be a reasonable explanation based on an analysis of many hundreds of cases."

The following classification of the war neuroses was adopted at Base Hospital 117:

1. Neurasthenia
2. Psychasthenia
3. Hypochondriasis
4. Hysteria
5. Anxiety neurosis
6. Anticipation neurosis
7. Effort syndrome
8. Exhaustion
9. Timorousness or state of anxiety
10. Concussion:
    (*a*) Syndrome
    (*b*) Neurosis
11. Gas:
    (*a*) Syndrome
    (*b*) Neurosis
12. Malingering

Some of these, such as malingering, are not neuroses at all, and others are questionable, but they are included in the classification for purposes of diagnosis because they represent conditions which a neurological hospital in the war zone is often called upon to handle. Dr. Schwab analyses the more important of these types in some detail. The symptoms of the first three—neurasthenia, psychasthenia, and hypochrondriasis—correspond closely to those of the civilian neuroses thus designated. In the first, fatigue is the predominating symptom; in the second, doubt, the inability to make a decision through fear of the consequences; and in the third, preoccupation with ideas of disease. The defense character of these three types is evident. All three are consciously originating neuroses. "This does not at all imply that they are either willfully or designedly produced, but that they play themselves out in the upper zones of consciousness and awareness."

Hysteria and the anxiety neuroses, on the other hand, "both represent unconsciously produced neuroses, and both are types of a dissociation process." In hysteria, the mechanism of dissociation blocks from consciousness and conscious control some functional activity, either in its motor, sensory, or psychical capacity.

"The dissociation process is most frequently set in activity by a somewhat sudden emotional or physical shock and, in the latter instance, the precipitating factor is most often the effect of a shell explosion or some type of trauma associated with some degree of violence.

The type of reaction in hysteria both in respect to localization and function bears a definite relation to the local effect of the trauma. Blindness is often the result of the acute blinding sensation of an explosion, deafness due to the momentary loss of hearing. For the same reason, sensory disturbances are due to numbing of areas of skin following disturbance of atmospheric pressure in the zone of an exploding shell, etc. The emotional precipitating factors have the same curious localizing tendency, with the exception that here suggestion or imitation seems to show a more active influence. It is necessary to point out that in hysteria, particularly the acutely established types, is shown less clearly the characteristic protective defense than in some other types of neuroses, and it must be admitted that in some instances it is only after the primary disturbance has manifested itself, whatever its nature may be, that the defensive mechanism is set to work and then chiefly in the direction of fixing it and making it more permanent.

"A sudden shock having a positive degree of physical incidence may throw out of activity a certain function or a part of it, certainly too rapidly for any kind of psychical mechanism to be set going. In such instances the instinctive action of self-preservation arises later, automatically making that loss of function fixed, thus establishing it as a neurosis of the war type."

Hysteria was the most easily cured of all the war neuroses and the anxiety neuroses were the most difficult.

"It is in the anxiety neuroses that the most complete example of psychical dissociation is met with—that is, a dissociation unaccompanied by anatomically expressed loss of function. It has to do with a more general process and reaches down more deeply into personality than the more superficially located mechanism seen in hysteria. Something of the etiology and the primary reaction have already been touched on. There remains to describe progress and final clinical results. The subject of an anxiety neurosis must be thought of as an individual in whom the repression faculty is well developed. This may come about either as a personal characteristic, or it may be due to the position of authority due to his military position. Naturally the officer falls most easily into this class, and it is in the officer class that the majority of instances of anxiety neuroses are found. . . .

"In almost all instances, an officer very early in his career, very likely even in the training camp, feels the necessity of repressing his dislike or objections to discipline, obedience, authority, and many of the other essential phases of military life. His repressive mechanism not only has to do with the ideas themselves, but also with the external evidence of his attitude toward them; that is, his conduct must depart in no way from the correct military form. For these, and indeed for most of the experiences associated with actual combat duty, the repressive function is amply sufficient to keep the officer from ever approaching the territory of the neuroses.

"The repression faculty has a well known tendency to become automatic and to act entirely without the intention of the individual. As the officer advances in his training, and as military life grips him more and more intensely, and as military discipline forms him into a silent part of the big army machine, he is less and less in need of any active manifestation on his part of this faculty of repression which was so much a part of the mental discipline of the earlier days of his training. It must not be forgotten that in the A. E. F. the professional class of officers was necessarily a small one and that most of the nonprofessional officers were taken out of civilian pursuits of various kinds in which no trace of military atmosphere and certainly none of active combatant duty were to be found. Therefore, there was no important set of military or officer traditions to which the future officer had long ago accustomed himself. In England, of course, there was, and there is no doubt that this had a definite influence on the number of anxiety neuroses among them.

"Therefore, it should be appreciated that in our army the traditions of conduct in general and particularly those associated with active military life had been very recently acquired, so recently that they were only superficially grafted on the officer's personality. There was need, then, to exercise, whether consciously or not, that form of inhibition called repression in order to maintain such traditions under circumstances of difficulty. This was especially necessary when the officer met front-line conditions for the first time, when he had not only himself to keep in hand, but also the added responsibility of men under him for whose fortunes in the stress of trench or open warfare he held himself in a measure responsible. In addition to this he realized that the technical side of his profession, a most difficult and intricate thing, was also but recently and often most laboriously acquired and had now to withstand the actual and often bitter test of real combatant conditions. Notwithstanding these heavy burdens, very few officers, it must be acknowledged, did, even under the adverse conditions associated with front-line conditions, develop a neurosis. Those who did had to face peculiar sets of circumstances which tended to break down the inhibitory processes which held them together in their capacity as leaders of men. Under the strain of fatigue, exhaustion, worry and some of the many incidents that have been before alluded to and as a result of shell explosion with a concussion sequence, the faculty of conscious inhibition was temporarily lost and the officer acted for the time being as a primitive, instinctive piece of human machinery and during the period of semi-automatism, confusion, or haze, the beginning of the neurosis of the anxiety type was laid. If some of these things did not happen in an acute manner, then a series of smaller and less important incidents brought the officer in exactly the same condition.

"From this time on, the conflict began to assert itself coupled with the dormant repressive tendencies, which again came into activity as the reality of the situation became more and more apparent. It is this antagonistic relation of conflict to repression that tends toward the separation of emotion from experience. This supplies the mechanism of dissociation alluded to before. There results then the clinical picture of a state of intense anxiety with the external evidences in the way of facial expression, depression, apathy, anxiety, loss of sleep, dreams and even the objective appearance of fear, tremor, rapid pulse, vasomotor reactions, in the face of the complete unawareness and lack of understanding on the part of the patient of what really is at the basis of his discomfort.

"The battle experiences repressed, and in a sense partially forgotten, tend to express themselves by freeing their emotional content or by spinning themselves out in dramatic and terrifying dreams. There is present, then, the evidence of fear and terror without being related to either actual experiences themselves or even to the actual memories of such experiences. In this state there develops a series of conflicts which must be regarded as being hardly conscious in some instances and wholly so in others. These seem to have been the more usual: (1) The conflict between the desire to go back to the front and the negative desire or wish for self-preservation. (2) The conflict arising between tradition and training of an officer and the desire to escape front-line conditions. (3) The conflict between the desire to avoid the dangers and discomforts of the front, and previous ideas of duty, valor, etc., and family, social, personal and class standards. (4) Conflict between the desire to escape and the feeling of inadequacy, in a military sense, of the responsibility of an officer in command of men. (5) Conflict between the impulse to go forward and the wish, expressed or not, to go back to former conditions in the United States. (6) Conflicts which have reference to events or similar types of conflict in pre-war experience.

"Naturally there are many other kinds of conflicts, but these were so common in the cases seen in Base Hospital 117 that some of them were predicted in certain individuals and were actually found to be present."

In the treatment of the war neuroses, certain general principles were followed at Base 117.

"The first principle of the hospital was to cure the soldier and send him forward. If this were not possible, he was to be fitted for military service in the S. O. S., with the hope that he would soon reach the front-line status. The very fewest cases were to be sent to the United States; therefore, D classification was permitted only in the absolutely hopeless cases, and these chiefly on account of some undercurrent organic malady or previously undiscovered organic lesion of the nervous system. . . .

"The second general therapeutic principle was that a patient's stay at the hospital was to be as short as possible—the average in the whole hospital was slightly above three weeks. This included the officer material which required long treatment, and also included delays in getting patients out, due to transportation difficulties and all other sources of block incident to a hospital operating at the time of active fighting.

"The third general therapeutic principle was that all attempts made to cure a patient should be instituted as promptly as possible—within forty-eight hours if it could be arranged. Associated with this was the idea, also, that when the attempt was made it should be followed through to a finish at one sitting. This, of course, refers only to the hysterical symptoms.

"The fourth principle was that the war neuroses were caused by a mechanism not under the patient's control in its initial phases, but subsequent to that, in two to four weeks, there might be a contributing factor in the retention of symptoms through the desire or wish of the patient to remain protected by his neurosis. At least this possibility was kept in mind, so that if a cure was not effected within that time, the question of the patient's coöperation was brought up.

"The fifth principle was that work of some kind was one of the most important aids in effecting symptomatic cures, so that always more than 80 per cent of the patients were engaged in work of some sort. This work was of a varied sort, work in the fields in season, road making, wood chopping and work in a special shop—a therapeutic workshop carried on by civilian aids. The only novel feature in this was that it was carried on in a hospital to meet war conditions within a comparatively short distance from the front areas."

In cases of hysteria and of anxiety neuroses, the treatment included explanations to the patient of the causes of his condition, so that he might understand it and coöperate with the hospital authorities in overcoming it. Special dependence was placed upon this method of treatment in the anxiety neuroses, which offered little opportunity for direct therapeutic attack.

"The therapeutic aim in the anxiety neuroses had formerly been to encourage the patient to forget his experiences and to aid by his own effort the automatic repressive tendency already existing. The new point of view was to attempt to train the patient to face, and to face daily as a matter of course, the experiences he had been through, no matter how uncomfortable or terrifying they happen to have been. This, by the way, was not original in this hospital. Charles Myers of Cambridge had carried out this process by means of hypnosis very early in his experience with cases of shell shock, and later Rivers had advised it as a perfectly feasible thing to work out without the use of hypnosis at all. It was in a sense a modified psychoanalytic procedure adapted to a war-born condition, divorced from a good deal of the technical complications of the method used in peace times.

"A patient was encouraged to talk about his experiences, to go over the emotional state which accompanied them, and to examine himself as critically as he could in reference to them. It is one thing to face a past event and to measure oneself in the light of that event; it is quite a different thing to try to forget an event and thus allow the criticism, so to say, to go on unconsciously and the resulting emotion to remain as the only conscious evidence of the conflict going on sublimated and beyond reach. The former state of mind was encouraged in the patient, the latter was to be avoided. . . .

"Therapeutic use was made of many other agencies not usually mentioned in describing methods of treatment. All of them had to do with strengthening the patient's morale, and forcing on his attention at all times the necessity of getting out of the hospital and back to duty.

"The hospital chaplain, Lieut. George Taylor, approached this through wisely and cleverly designed sermons touching on the spiritual phases of courage, loyalty, devotion and patriotism. The sermons and religious exercises were planned in part toward this end, as were the weekly talks by members of the staff and sometimes by visitors to the hospital. In other ways the military atmosphere was kept alive by every means possible. The decorations in the recreation huts were all planned to keep the military atmosphere in the minds of the soldiers through stirring posters and scenes of actual war conditions. The walls were covered by sketches, drawn for the most part by patients, of men going over the top, artillery going into action, aeroplane fights, etc.

"Sympathy in the ordinary meaning of the term had little place in this hospital; intelligent insight and appreciation of the mechanism of the war neuroses in a measure took its place. The military necessity was accentuated and kept constantly in mind, but notwithstanding a certain grimness in the hospital's attitude to its patients, not the slightest suggestion of harshness or severity was ever permitted. The war neuroses were regarded as temporary conditions into which a soldier might fall and thus become a subject for medical treatment. The treatment was bound to fail unless the efforts made to help him met with the coöperation of the patient and a desire on his part to get well. The hospital was planned and equipped for the purpose of returning him to duty and, given his support, did in most cases succeed. If expressing his recent experiences by talking, writing, or even, as was done in some cases, by the most lurid drawings was an aid to this end, such efforts were encouraged by whoever might happen to be at the time helping on his case, be it *padre*, civilian aid, nurse, or some other specially qualified member of the hospital personnel."

About 65 per cent of the men treated at Base Hospital 117 were returned to active duty; about 30 per cent were sent to S. O. S. duty; the remainder were judged to be totally unfit for military duty of any kind.

"In the forward neurological stations the percentage of returned cases was much larger, and in the *triages* larger still. This means, of course, that the prompt treatment of incipient cases at the hands of experienced men can prevent in many instances the full development of the neuroses in a fixed form."

In closing, Dr. Schwab emphasizes the importance of bringing to bear upon the problem of civilian neuroses the knowledge, insight, and experience gained in the treating of the war neuroses.

"If this is not done, the war neuroses are no more than an evanescent item in the casualty lists. The war neuroses are specific war-born conditions, and with the ending of the war they disappear from clinical experience. Their place is taken by the civilian neuroses, which are different things.

"What remains are the mechanisms and therapeutic methods. These are the unchanging elements and understanding them is the permanent gain. All that is necessary is to replace the conflict of battle by the conflicts which result from social and economic stresses, to substitute less fundamental instincts for that of self-preservation, and to cultivate in treatment the same therapeutic eagerness, definiteness and incisiveness which were found effective there. If this is done, the 'return-to-duty' cases in the civilian neuroses will reach and pass beyond that which was possible among the soldiers who were treated in the various divisions of the neuropsychiatric organization of the A. E. F."

BOOK REVIEWS

EDUCATION FOR CHARACTER. By Frank Chapman Sharp. Indianapolis: Bobbs-Merrill Company, 1917. 453 pp.

This book is a clear, concise, and practical outline of the simple, fundamental principles of everyday morality, written especially for the schools, with the common sense and insight of a practical teacher. That it merits a review in MENTAL HYGIENE is clear when we reflect that the fields of mental hygiene and of practical morals overlap, and that precisely these simple, fundamental principles of morality are, in many cases, likewise fundamental principles of mental hygiene.

If one presents the commonplace rules for mental hygiene for the normal, and the simple principles of social education essential for the development of healthful habits of mental activity, the comment is likely to be made that it is morals rather than hygiene that one is discussing; and if, on the other hand, an ethical writer presents, as Professor Sharp has done, the commonplace rules of practical morality and gives practical suggestions for moral education, the hygienist at once recognizes that in large part precisely these rules and principles are vitally significant for mental health.

The sooner we recognize this common ground of morals and mental hygiene, the better. For centuries the chief literature of mental hygiene was that written by the moralists and religious writers. It is true that this contained a large amount of superstition and error; but gradually a universally recognized code of morals has been developed, and this has been also a great contribution to mental hygiene. And to-day the contributions of scientific mental hygiene are of the utmost importance for moral and religious teachers. In a word, hygiene can learn much from the amateur mental hygiene of the moralists—that nucleus of common-sense, practical wisdom gradually developed by the experience of the race; and, on the other hand, nothing is more vitalizing and practically helpful for the moralist than the contributions of the scientific mental hygiene of to-day.

Professor Sharp discusses with practical illustrations and suggestions such topics as the place of moral education in the school, the influence of personality, the tone and discipline of the school, the extracurricular activities of the school, the work of the teacher, and moral training in its various aspects, together with the practical methods of moral instruction and training that may be utilized in the home and the school.

The chapter on moral education in the home gives perhaps the best illustration of the common field of mental hygiene and of morals just mentioned. If the simple principles here discussed and the practical suggestions given were followed in home education, it is not too much to say that a large number of cases of nervous and mental defect would be prevented. Precisely such principles and methods are those adopted as the most helpful in the reëducation of nervous and mental patients in the hospitals and sanitariums. That the application of these in home and school education would be far better for prevention than for cure is obvious.

Mental hygiene emphasizes the fact that one of the most important conditions of mental health is the development of right attitudes toward others and toward life. These, of course, are formed largely in the home. A single concrete illustration of the overlapping of hygiene and morals is furnished here by Professor Sharp's discussion of the trite, but vital, subject of example.

"When a child sees his father treat his mother like a boor, how is he likely to treat his sisters? When the conversation at the dinner table consists chiefly of malicious gossip, innuendos, sarcastic flings at neighbors or relatives, a cynical interpretation of other people's motives, assumptions that what the parent speaking does must be right and that any one who denies it must be either a fool or a knave—with what views of life and of himself is he likely to grow up?" Such attitudes are dangerous from the point of view of hygiene as well as of morals.

Again, as regards the subject of punishment, Professor Dewey's article in the *Popular Science Monthly* on *The Chaos in Moral Training* is cited; and Professor Sharp adds: "What does most harm, perhaps, because it rankles longest, is injustice in punishment. Professor Dewey once made a collection of the youthful experiences of his students in this matter. One boy was whipped for taking his father's tobacco and using it. No questions were asked and no explanations given. The boy thought his father whipped him because he wanted the tobacco himself. A girl saved pennies which her father had given her to take to Sunday school and bought a valentine with them which she gave him to surprise him. The father threw this into the fire first and then punished her, taking it for granted that she knew she was doing wrong. Not even after that, however, did she feel it was wrong, but rather felt indignant and humiliated that her father had treated her gift in such a way. . . . Few things that the parent can do will have a worse effect upon a child than inflicting undeserved punishment. The effect of such treatment upon one of Professor Dewey's students was that he longed to become old enough to retaliate. One way to avoid such tragedies is not to permit one's self to punish in wrath."

Such practical illustrations and the application of moral principles to school work commend this book to teachers, and indirectly its contribution to mental hygiene is important.

WILLIAM H. BURNHAM.

Deficiency and Delinquency. By James Burt Miner. Baltimore: Warrick and York, 1919. 355 pp.

The author, when confronted a few years ago with the mental measurement of delinquents in the Hennepin County Juvenile Court at Minneapolis, found himself very much in need of a statable border line of intelligence defect for adults. With the full recognition that intellectual defect constitutes only one symptom of feeblemindedness, it appeared to him perfectly logical that there is an upper limit of intelligence or intellectual capacity which may in and for itself be considered a sufficient reason for antisocial behavior.

With this point of view in mind, he selected objectively a group of fifteen-year-old children in Minneapolis, where the school registration is accurate and effective. In seven typical districts of the city there were 653 fifteen-year-old children, 322 of whom were boys. Among these were 196 who had not graduated from the eighth grade. These were measured by the Binet 1908 scale, with the exception of one child, who was in a hospital on account of illness. A thorough search was made for fifteen-year-olds from these districts in institutions. None was found.

As a result of this thorough study of the lower-grade fifteen-year-olds in these typical districts of the city of Minneapolis, the author finds substantial evidence for the view that the state may be justified in isolating indefinitely the lowest 0.5 per cent of the population mentally on the basis of their decided lack of intellectual capacity. The next highest 1 per cent, comprised of those between 0.5 per cent and 1.5 per cent, of fifteen-year-old intelligence, being in life age fifteen years or older, he finds himself justified in calling "the social-assistance group." Many of these will prove by their delinquencies that they are feebleminded, and all of them may be expected to require social assistance indefinitely.

The Minneapolis data from these normal fifteen-year-olds, and the results presented from the Glen Lake Farm School, near Minneapolis, constitute the original contributions of this monograph. The main contention, however, is for a percentage definition of deficiency as against an intelligence quotient, a coefficient of intelligence, or amount of deviation from the normal, as a means of judging feeblemindedness. Notwithstanding the "natural antipathy of many people to anything which tends to limit the charming vagueness of their mental outlook," the author proceeds to make a very thoroughgoing review of the effect of applied psychology in the field of delinquency in the past decade while it has worked without definite limitations of the concept of feeblemindedness.

He shows, for instance, that the standard used by Dr. Printner in his report of one hundred juvenile-court cases, if applied to the Minneapolis group, would have classed 20 per cent of them as feebleminded, instead of the 2 to 7 per cent thus classed under the author's more conservative border lines. He comments on Dr. Hickson's classing "728 boys who average XI.11 years as morons," while he considers ten-year mentality the probable limit for persons fifteen years or more of age. He assembles in one table the results of about forty different studies of groups of delinquents, standardizes these according to his own percentage definition, and finds the very large percentages stated for the Newark Detention Home, New Jersey, and the Allegheny County Juvenile Detention Home, Pennsylvania—percentages stated as 66 and 55 respectively—to be due to the fact that these institutions harbored unusually large numbers of recognized feebleminded delinquents, because the states concerned had not made proper provision for the same in institutions designed for mental defectives. In fact, the author traces a general tendency to overstate the percentages of mental defectives among delinquents to the very large numbers which Gifford and Goddard found in the Newark Detention Home.

In his discussion of deficiency as a cause of delinquency, presenting evidence from Goring and the Report of the British Royal Commission on the Care and Control of the Feebleminded, he states "these estimates afford a telling argument for the indefinite isolation of at least those who are in the lowest 0.5 per cent mentally on the ground of their potential criminality, independently of any question of the danger to society from the hereditary transmission of the diathesis of deficient delinquency."

A few chapters near the end are devoted to theoretical considerations, taking up the theory of measurement of mental development and quantitative definitions of the border line. Karl Pearson's suggested use of standard deviation, i.e. of −4 S D as a border line, is shown to be inapplicable to other school surveys than Jaederholm's at Stockholm. The percentage limit, with the author's suggested one-half of 1 per cent of the general population, is found to be much more serviceable and, until we know more of the facts involved, as scientifically accurate a means as is available for separating the intellectually deficient from any given population. We possess at present no statable units of measurement in terms of which mental retardation can be expressed. The percentage definition is reasonably accurate and will have the effect of tempering and equalizing the statements of different workers in various fields of delinquency.

THOMAS H. HAINES.

SPEECH TRAINING FOR CHILDREN; THE HYGIENE OF SPEECH. By Margaret Gray Blanton and Smiley Blanton, B.S., M.D. (University of Wisconsin). New York: Century Company, 1919. 261 pp.

This book is a definite contribution to the science of mental hygiene. More closely, it might be spoken of as a study of the hygiene of emotional expression in children with special reference to speech. While the book is written primarily for parents and teachers, it is of especial importance to the physician, who is interested in recognizing and correcting in children the first traces of what may, if left uncorrected, give rise in later years to nervous or mental handicaps. The book abounds in concrete suggestions for the stimulation of healthy emotional and intellectual growth. It contains wise estimates of commonly practised methods of dealing with children and discusses measures for the correction of unfortunate habits in children and adolescents.

From the standpoint of the authors, the orderly development of intellectual and emotional functions is dependent upon a general capacity for muscular coördination—a development of the kinaesthetic sense—adequate to favor a free adjustment to the child's environment, and to facilitate by it at the same time a free flow of the appropriate feeling or emotion. Defects of expression in speech, the authors reiterate, delicately guage irregularities of this development. Hence, by intelligent heed to the speech of the child, the authors claim, much may be discerned of crucial importance in its inner life. Difficulties of expression by speech are therefore to be corrected, not only by attention to the vocal and enunciatory apparatus, but also, and often mainly, by attention to more fundamental functions. In this latter connection, the authors emphasize the matter of unfortunate emotional tension.

For the reader who wishes formal directions and means for carrying into effect the suggestions of the text, the authors have provided nearly sixty pages of exercises. In these, as in the text, the authors maintain an attitude of appreciation of the problems from the standpoint of the child and yet reach by precision the end sought.

The book is written in a clear style free from tedious technical details. It should go far in stimulating an interest in a function as much neglected in its purely educational bearings as in its importance in relation to mental hygiene. The authors present in summary one aspect of their interest as follows: "The child cannot dominate the world. If he could, it would not bring him happiness. . . . The earlier he is taught the simple—in the beginning—practice of looking at his needs from the point of view of society, desiring for himself only those things that would be reasonable if demanded by the whole race, and accepting those things that it were not well should be changed, the greater will be his opportunity for normal emotional life and healthy spiritual development. Normal speech is only present where these two attributes are present."

G. S. AMSDEN.

HANDBOOK OF MENTAL EXAMINATION METHODS. By Shepherd Ivory Franz. Second edition, revised and enlarged. New York: The Macmillan Company, 1919. 193 pp.

The second edition of Professor Franz's handbook appears at a particularly opportune time. The renewed and increased interest in psychiatric problems and the distinctly important place they now occupy in medicine and public health have given rise to a demand for information on methods of approaching and elucidating these problems. There is, too, a demand for more exact and standardized methods.

Professor Franz in his book meets these needs to a very large extent. The handbook sets forth briefly and clearly each subject to be investigated and then, with equal clearness, describes the methods of observation and tests to be applied. The new chapter, XII, *Mental Tests*, is especially worthy of careful reading. It is also interesting to find that the author thinks well enough of Woodworth's *Tests of Emotional Instability* to include it in his book.

While Professor Franz writes largely from the standpoint of a psychologist, his handbook will be found invaluable by all who are interested in the examinations of mental disorders.

M. W. RAYNOR.

CONDUCT AND ITS DISORDERS, BIOLOGICALLY CONSIDERED. By Charles Arthur Mercier, M.D., F.R.C.P., F.R.C.S. New York: Macmillan Company, 1911. 377 pp.

The author undertakes in this book a systematic presentation of the nature and varities of human conduct and its disorders and an outline of a science of "Praxiology" as distinct from "Psychology." In the very first page of the introduction, we come across the statement, "In treating of conduct it is desirable to eliminate, as far as possible, reference to mental states and processes."

In so far as the subject of human behavior lends itself at all to this type of treatment—i.e., to a treatment of it without reference to psychology—the author has accomplished his task well.

The book does furnish a lucid and systematic presentation of the nature of action, of the different kinds of action of which man is capable, of the ends that he seeks to compass, of the relative importance of these ends, of the harmony or conflict among them, of their subordination and superordination to one another, and of the biological reasons on which they are based.

It is difficult, however, to follow the author in his explicit intent to avoid psychological considerations in the treatment of his subject. Already, in the discussion of instinct and instinctive behavior, to which Mercier devotes two very interesting chapters, the ignoring of psychological factors would bring him into conflict with the more widely accepted theory of the nature of instinct, namely, that it is an inherited or innate psycho-physical disposition involving psychical as well as physical elements and possessing cognitive, affective, and conative aspects. As might be expected, therefore, Mercier does not succeed entirely in avoiding reference to psychological states, as one can see from a glance at the chapter headings.

The book is divided into two parts, the first part being devoted to a study of action and the second to a consideration of the ends which conduct strives to attain and of the means by which these ends are compassed. The thorough systematization which the author has succeeded in achieving is very striking and is especially evident in the first half of the book. Thus the subject of the varieties of human action is embraced in eleven sets of contrasting pairs as follows:

Action may be spontaneous or elicited; abundant or scanty; instinctive or reasoned; self-indulgent or self-restrained; impulsive or deliberate; voluntary or involuntary; novel, habitual, or automatic; orignal or imitative; crude or elaborate; work or play; skillful or unskillful. Naturally any single act may exhibit qualities from several or all of these contrasted couples.

The detailed consideration of these varities of action is particularly illuminating because of the lucidity of presentation and the richness of concrete illustrations.

In the remaining half of the book, which comprises chapters VI to XXII inclusive, the ends and purposes and the various modifications of conduct are treated. There are chapters on directly self-conservative conduct and indirectly self-conservative conduct; on the nature of social conduct, with a discussion of the influence upon conduct of the mere existence of others and of the presence of others, of the attention and estimation of others, of their approval, liking, exercise of will, and example. Then follows a discussion of the action of others on ourselves, on others, on circumstances. Spontaneous social conduct, with a detailed consideration of patriotism, philanthropy, and spontaneous morality, is the subject of the next two chapters.

Then follow three chapters on social-racial and more specifically racial conduct, with a discussion of such topics as chastity, modesty, courtship, jealousy, marital, parental, and filial conduct. Chapters on recreative and aesthetic conduct, on investigation, and on religious conduct complete the book.

This extremely rich content of Mercier's book leaves one, however, with a feeling of partial satisfaction only, in spite of its apparent completeness, and this feeling is undoubtedly due to the fact that the very suggestive contributions of analytic psychology are given no consideration in the book.

One must look for Mercier's attitude towards the analytic school of psychology in a more recent book of his on crime and criminals, published this year.

In speaking of the theory of the unconscious, on page 41, he says, "It is obvious that a state of mind that is unconscious is not a state of mind, any more than a solid body that offers no resistance is a solid body. It is nothing. The words are without meaning." This is followed by a bitter denunciation of psychoanalytic practice. But in spite of this regrettable attitude of the author towards the Freudian school, his book will be found to be exceedingly helpful for a systematic orientation in the field of human conduct, albeit overt conduct.

BERNARD GLUECK.

DISPENSARIES: THEIR MANAGEMENT AND DEVELOPMENT. By Michael M. Davis, Jr., Ph.D., and Andrew R. Warner, M.D. New York: The Macmillan Company, 1919. 438 pp.

Medical officers returning from the army, where many for the first time had an opportunity to work in a large organization and where, strangely enough, many for the first time had brought forcefully to their attention the social aspects and responsibilities of their profession, are showing a greater interest in community problems and in the possibilities of professional "team play" in solving those problems. A medical officer could not stand in an examining line day after day, while thousands of youths passed him, and man after man was thrown out for what might in all truth be called inexcusable defects, without sooner or later having ring in his ears the words "neglect," "unnecessary," "carelessness," "ignorance." He could not walk his wards month after month, seeing men desperately ill get well and men crippled apparently beyond repair regain a more than reasonable amount of efficiency—because of an organization that permitted accomplishment and a pervading spirit that defied the impossible—without remembering civilians in much less desperate straits who die or lose efficiency through neglect or failure to obtain early diagnosis and advice, and industrial cripples left stranded because of lack of interest and of organization in caring for them. He could not live the life of a soldier in cantonment, observing the alertness, expertness, and success of his brother officers, the epidemiologists, in guarding every avenue of infection to the camp, without recalling the weakened defenses in his home community. He could not lose his resentment at having his ward placed next to the neuropsychiatric ward, as he found that in no way did this ward disturb his own, without sooner or later coming to wonder why such reasonable methods of care for nervous and mental patients are not used in civil hospitals—why, in his city of five hundred thousand, patients are jailed or neglected until they become a more or less total loss and a permanent charge upon the community when in a military city of forty thousand or twenty-eight thousand similar patients are, with a simple equipment, cared for at the beginning of their illness and helped and restored. He could not see a listless, gloomy ward transformed by the entrance of the occupational-therapy worker without thinking of his idle, restless, discouraged hospital patients at home. He could not have record after record made clearer through the information brought to him by the social worker without recalling his civil mistakes due to lack of just such information. In other words, with the evidence before them, month after month, of the impossible accomplished through organization, expertness, coöperation, and "team play," many medical officers were brought, as it were, upon a mountain where, in the presence of a vision, they shed much of their "individualism."

But not only did medical officers see and think deeply upon these things. Nurses, social workers, Red Cross workers, and many others who in one way or another came into contact with the medical organization in the army, saw too, and, returning, are aware as never before of the desirability and the possibility of "organizing for health." In consequence there is a stirring throughout the country such as has never been known before. Cities and states are examining into their condition and planning for the future. Health centers are being discussed and in some places organized. Formerly well established clinics are extending their activities. New clinics are rapidly being established.

At this opportune time, when many physicians and lay assistants are enthusiastically entering a field that is more or less new to them, when plans of method, of organization, of administration must be considered, comes this book on dispensaries by Doctors Davis and Warner. It is an excellent book. There is not a chapter but contains material that will be of value to some earnest, but puzzled worker.

The authors state their object as threefold: "First, to depict briefly the history and present extent of dispensaries in the United States; second, to present the practical details which all people, including superintendents, physicians, nurses, and social workers, who are working in dispensaries particularly need to know; three, to present the dispensary as a form of organization, not only for rendering efficient medical service to the people, but to benefit the medical profession by stabilizing the economic position of the average physician," and it can be said that each object is reasonably attained.

It is a privilege to be able to call attention to this book, and it is to be hoped that it will be generally read by those who are planning community clinics.

Frankwood E. Williams.

A Study of the Mental Life of the Child. By H. Von Hug-Hellmuth, M.D., Washington: Nervous and Mental Monograph Series No. 29, 1919. 154 pp.

Works on child psychology are apt either to be of anecdotal interest or to overdo unproductive analysis of special functions; the psychologist, whether dealing with the child or the adult, has as a rule fought shy of some of the most important determinants of human behavior, especially the sexual instinct. This shyness of the child psychologist has tended to sterilize his special branch of psychology. It is, therefore, gratifying to find a work in which the author is willing to give full value to factors too long neglected, and to discuss the actual life of the child without embarrassment.

Unfortunately the author rather overshoots the mark and not only discusses frankly the rôle of the sex instinct in the child's life, but insists on interpreting in sexual terms many sources of pleasure the relation of which to sex is extremely doubtful. The lay reader, not skilled in discounting accurately this overemphasis on sex, is apt either to lay the book down in alarm or to swallow it uncritically as a wonderful revelation.

The book is worth careful study, for in spite of grotesque exaggerations here and there, it is full of valuable observations and gives a picture of child life that in many ways is more stimulating and of more practical help than the usual books on child psychology. The translating has been admirably done.

C. MACFIE CAMPBELL.

BROKEN HOMES. By Joanna C. Colcord. New York: Russell Sage Foundation, 1919. 208 pp.

The problem of desertion of the family is one that is a little difficult to treat as a special topic, as it always occurs in such a complicated setting. No single formula can be supplied for it, no general principles will cover adequately the complexity of the individual cases. Social workers, however, find the topic bulking so largely in their work as to deserve separate consideration.

In this book Miss Colcord gives an excellent discussion of the whole problem. She emphasizes its complexity, and keeps always before the reader the necessity of thinking in terms of the concrete situation. The book is based upon detailed case-work; the various causes which have been found to be operative in desertion are discussed in a very satisfactory way. The practical steps to be taken in regard to the situation are gone over with a full realization of the complexity of the problem.

The book is written in excellent style, and throughout the author shows very good judgment in her discussion of the various problems.

C. MACFIE CAMPBELL.

MORTALITY STATISTICS OF INSURED WAGE EARNERS AND THEIR FAMILIES. By Louis I. Dublin, Ph.D., with the collaboration of Edwin W. Kopf and George H. Van Buren. New York: Metropolitan Life Insurance Company, 1919. 397 pp.

This volume gives an analysis of the 635,449 deaths among the policy holders of the industrial department of the Metropolitan Life Insurance Company during the period 1911 to 1916. It constitutes a comprehensive treatment of the entire field of mortality as related to wage earners and their families.

It was found that the general annual death rate per 1,000 persons exposed was 11.81; among the white the rate was 11.04 and among the colored 17.22; among the white males it was 11.22 and among the white females 10.40; among the colored males it was 17.63 and among the colored females 16.89. A comparison of mortality from all causes among white males and colored males, classified according to age, shows that there is a higher death rate among colored male wage earners during each age period. The difference in rate is greatest in the age group 20 to 24. There is likewise a higher death rate among colored females than among white females at each age period. The difference is very marked between the ages 15 to 65. Comparing the death rates of the several years covered by the study, we find that the general death rate declined from 12.53 in 1911 to 11.68 in 1916. The rate among the white males declined from 12.58 to 11.83; among the white females from 11.11 to 10.21; among the colored females from 17.50 to 16.85. The rate among the colored males increased from 17.42 in 1911 to 17.68 in 1916.

The influence of the principal diseases on the general mortality rate is carefully analyzed, a chapter being devoted to each of the diseases that cause a high percentage of deaths.

Tuberculosis, in all its forms, accounted for 110,363 deaths, or 17.4 per cent of the 635,449 deaths in the entire industrial mortality experience for the six-year period 1911 to 1916. Of these deaths, 93,526 were caused by tuberculosis of the lungs. The death rate among the colored from tuberculosis was more than twice as great as that among the white wage earners. A ray of encouragement is noted in the decline of the death rate from tuberculosis per 100,000 from 203.0 in 1911 to 172.8 in 1916. The rate among the white males declined during this period from 210.4 to 178.1; among the white females from 148.4 to 122.8; among the colored females from 375.1 to 336.8. Among the colored males the rate increased from 378.7 in 1911 to 386.8 in 1916. The low rate among white females in 1916 is especially noteworthy.

The deaths classified as due to organic diseases of the heart are second in numerical importance to tuberculosis in this mortality experience of insured wage earners. Of the 635,449 deaths, 75,345, or 11.9 per cent, were reported as due to organic cardiac diseases. The general death rate from these diseases per 100,000 was 140.1. Among white males it was 125.9; among white females 137.0; among colored males 191.0, and among colored females 202.0. An analysis of these deaths by ages shows that the rates are comparatively low up to the age of 35. From that time they increase very rapidly. Among the white a decline in the death rate from cardiac diseases from 1911 to 1916 is noted, while among the colored an increase in rate is noted during the period.

The third most prominent cause of death among the wage earners studied was pneumonia, a total of 57,931 deaths being reported as due to some form of this disease. Of these 41,707 were due to lobar and undefined pneumonia, and 16,224 to broncho-pneumonia. The general death rate per 100,000 from lobar and undefined pneumonia was 77.5; among the white males the rate was 82.6; among the white females 63.0; among the colored males 141.5; among the colored females 97.2. The general death rate from lobar and undefined pneumonia decreased from 89.2 in 1911 to 80.8 in 1916. In 1915, however, the rate was 74.4.

The fourth most important cause of death found in this study was "Bright's disease," which term includes chronic interstitial nephritis, chronic parenchymatous nephritis, chronic diffuse nephritis, and nephritis undefined. It does not include acute nephritis. A total of 52,067 deaths were reported as being due to these causes. The general death rate per 100,000 was 96.8. Among white males the rate was 97.1; among white females 88.1; among colored males 138.7; among colored females 121.3. The general rate increased from 95.0 in 1911 to 99.0 in 1916. The increase was more marked among colored than among white wage earners.

External causes of death, including accidents, suicides, and homicides, accounted for 50,712 deaths among the group studied. The general death rate per 100,000 from these causes was 94.3. From accidents alone the rate was 73.0; from suicides 12.2; from homicides 7.0; from war deaths 2.1. An analysis of the mortality from various forms of accidents and injuries shows that the rate is very much higher among males than among females, and also that the rate from steam-railroad accidents and injuries is declining, while that from automobile accidents and injuries is increasing. Mortalities from street-car accidents and injuries from other vehicles excepting automobiles show a marked decrease during the six-year period. The figures compiled with reference to suicides seem to indicate a decline in the rate, but the authors call attention to the fact that suicide mortality is subject to considerable fluctuations with community conditions and that an opinion of the real trend of this phenomenon must be founded upon facts covering a long period of time and only after the fluctuations characteristic of suicide are in full view.

The study makes a very careful analysis of the various forms of cancer reported as causes of death. Altogether there were 37,666 of these cases. The death rate per 100,000 from cancer was 70.0. The rate among white males was 50.4; among white females 88.4; among colored males 31.0; among colored females 87.8. The figures compiled indicate a slight rise in the mortality rate from cancer from 1911 to 1916, but the authors state that "It is probable, though far from certain, that cancer mortality is not increasing."

Cerebral hemorrhage and apoplexy were assigned as causes of death in 36,638 cases. The average annual rate per 100,000 exposed was 68.1. The rate among the white males was 60.2; among the white females 69.5; among the colored males 76.9; among the colored females 97.4.

The figures show a decided jump in the rate from 1911 to 1912. Since 1912 the rate has apparently declined, but the change has been slight. In view of the difficulty experienced in securing uniform reports concerning this disease, the changes in rate indicated are not of great significance.

Reported deaths from syphilis, including locomotor ataxia and general paralysis of the insane, number 7,680. The combined death rate from these diseases was 14.3 per 100,000. The authors point out the fact that these figures represent an utterly inadequate measure of the incidence of syphilitic disease.

Several other forms of diseases are discussed in detail and figures are submitted to show the trend of mortality from each. The work throughout has been very carefully done and the presentation is most excellent. The work as a whole constitutes a very important contribution in the field of vital statistics.

HORATIO M. POLLOCK.

THE MENTAL HYGIENE OF CHILDHOOD. By William A. White, M.D. Boston: Little, Brown and Company, 1919. 193 pp.

Modern psychopathology is daily laying more and more stress on faulty development and is therefore assigning to the environment of the child a large share of blame for the nervous and mental diseases of adult life. Consequently intelligent parents are demanding literature which may give them the education necessary to meet these newly recognized responsibilities. The "Mind and Health Series" has met this demand in a timely way by giving us Dr. White's concise and simply written manual.

He begins, logically, with a definition of the child, exposing the unconscious fallacy which actuates so much ill-treatment of children, namely that the child is a little adult, whose mind works with grown-up mechanisms and is prompted by the same standards of conduct and ambitions as the parent's. Then follow five chapters in which he describes the instincts, instinctive development, and environment of the child. This is a frankly psychoanalytic exposition, but avoids the crudities and exaggerations found in many psychoanalytic writings. Some psychologists might dispute his categories, particularly the "Race Preservative (Sexual) Instinct." This is made to cover what are generally regarded as sexual tendencies, the bonds with society, and also all pleasure-pain impulses. Less gymnastics might be needed if the author were willing to postulate a herd instinct as well. The remainder of the book, apart from a chapter on the history of social treatment of the child, is concerned with the problems of education, punishment, sexuality, repression, and play. This second section deals admirably with the problems raised by the psychoanalytic theories of the first part of the book. So far as the reviewer is aware, no one has as yet furnished us with anything like as clear a set of generalizations for the guidance of teachers and parents.

But the book has one grave defect. It is too short. Its brevity accounts fully for two disabilities. The layman is not a clinician nor a psychologist. The readers of this work will be looking for help in guiding the development of normal, or relatively normal, children. It is a far cry from "Peter Pan" to the child depicted in the first chapters. The parent is apt, we fear, to regard this as a picture of the psychopathic child and not a likeness of her little innocent. Sympathetic study will show that the author has not lost his perspective, but that, crowded for space, he has stressed those features of childhood which are potentially malignant. Unfortunately, one cannot count on sympathetic studiousness, and first impressions may be accepted as fixed prejudices. Secondly, solutions offered for the problems presented are, perhaps, too vague for the inexperienced to assimilate. If the book had been twice the size and replete with examples of definite situations, its practical value would be increased many fold.

As it stands, however, it is invaluable. If one reader out of ten can appreciate the truth which is offered him, the next generation will be much happier and healthier than this. For instance if he can see how he has been indulging his own complexes, his own whims, while he thought he was training the child in the way he should go, all children under his authority will benefit hugely. If the author had done nothing but write the chapter on *The Function of the Parent*, he would have made the layman greatly his debtor.

JOHN T. MACCURDY.

MANAGEMENT AND MEN. By Meyer Bloomfield. New York: The Century Co. 591 pp.

The author of this book has a national reputation in dealing with questions of personnel. The present volume concerns the labor situation in England. It consists largely of material prepared for the *Saturday Evening Post* in the course of a visit to Great Britain for the purpose of studying British industrial developments. The text is a straightforward account, without literary pretensions, of what is happening—how the mass problems of mental adjustment are being met. Naturally, a dominant note is the demand by workers for a greater share in the management of industrial affairs and a discussion of the means by which this can be attained. The Whitley plan looms very large through the book in this connection. Great developments in coöperative purchasing are described. It is not anticipated that the readjustment will involve destructive upheavals.

Considerably over half the volume is occupied by an appendix, which reprints documents related in various ways to the labor readjustment and goes further into the details of the matter than does the text itself. The appeal of the book is distinctly to those who are in immediate contact with the management of industrial personnel, and to their work it should prove a very helpful manual of suggestions.

F. L. WELLS.

THE CHILD'S UNCONSCIOUS MIND: THE RELATION OF PSYCHOANALYSIS TO EDUCATION. By Wilfred Lay, Ph.D. New York: Dodd, Mead and Company, 1919. 325 pp.

There can be no ambition more lofty than that which prompted the writing of this book, for no study could be more important than that which is discussed by the author. Any enlightened lover of his kind would admit that a thorough knowledge and control of the unconscious mind of the child of this generation would produce in the next a race free from our most grievous problems. Whether one agrees with the tenets of psychoanalysis or disputes them, he must admit that the object, at least, of the psychoanalyst's study—the instincts and their secret workings—is the prime factor in settling the fate of the human species. The ambition of the author is therefore commendable.

But his achievement cannot merit so much praise. The first half of the book is devoted to a tedious description of the *adult* unconscious mind and its workings. In places it is well illustrated with original examples, but in general much space is taken up with elaborate, academic formulations and efforts to ally dynamic psychological principles with hypotheses concerning the physical basis of emotions, which hypotheses are accepted as facts. The work is addressed to parents and teachers, who can not be expected to take a feverish interest in such abstruse speculations. After each principle is discussed, the author pulls himself up with a jerk, remembers his title, and states that all this begins in childhood. In the second half, he is more interesting when he discusses the educational implications of psychoanalytic theories. He makes a number of good, practical suggestions, but each can easily be seen to be the product of common sense and sympathy. Wherever he attempts to apply his "science," he becomes hopelessly vague, directing a recognition and treatment of individual unconscious tendencies which could be unmasked only by a tedious individual analysis. He must be credited, however, with one—and an outstanding—virtue. He constantly inveighs against the current systems of education which look on individualism in taste as naughtiness and individualism of conduct as pure immorality. If the parent or teacher who plows through these many pages can glean but this one point and study anomalies before attempting to correct them, the book will have justified itself.

In conclusion it may be well to point out that the author is not alone in his guilt of discussing primarily the mind of the adult rather than that of the child. So far as the reviewer is aware, only one extended analysis of a child has ever been published, and that many years ago by Freud. The implications of psychoanalysis unquestionably point to the origin of unconscious tendencies in childhood, but *children* have never been adequately studied. The few works extant describe a life grotesquely full of morbid sex fancies or else an idealized nursery where little angels laugh and sing. The truth presumably lies between, and it has not yet been given to us.

JOHN T. MACCURDY.

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THE NATIONAL COMMITTEE FOR MENTAL HYGIENE, INC.
FRANKWOOD E. WILLIAMS, M. D., *Associate Medical Director.*

Sworn to and subscribed before me this 6th day of October, 1919.

M. A. FOWLER, *Notary Public.*

My commission expires March 30, 1920.
Form 3526.

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